A G E N D A

MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

THURSDAY, 7:00 p.m.
2011 April 14

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

MEMBERS OF THE BOARD OF HEALTH

Ms. Patricia Coderre (Chair)	Ms. Viola Poletes Montgomery (Vice-Chair)
Ms. Denise Brown	Ms. Nancy Poole
Mr. Al Edmondson	Mr. Don Shipway
Dr. Francine Lortie-Monette	Mr. Mark Studenny
Ms. Doreen McLinchey	Mr. Joe Swan
Mr. Marcel Meyer	Dr. Graham Pollett (Secretary-Treasurer)

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF MINUTES

APPROVAL OF AGENDA

SCHEDULE OF APPOINTMENTS

7:10 – 7:20 PM Ms. Maria Sánchez-Keane, Principal Consultant, Centre for Organizational Effectiveness re Item #7.

7:20 – 7:30 PM Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual Health Services re Item #8.

ACTION REQUIRED

1) Report No. 035-11 re Two New Full Time Equivalent Public Health Nursing Positions

2) Report No. 036-11 re Call for Action Against Smoking in Movies

3) Report No. 037-11 re Records and Information Management Program - Revised Policy 6-030

4) Report No. 046-11 re Appointment of Mr. Al Edmondson to alPHa Board of Directors

5) Report No. 041-11 re Changes to Ontario's Alcohol Regulatory System – Liquor Licence Act

FOR INFORMATION

6) Report No. 038-11 Medical Officer of Health Activity Report – April

7) Report No. 039-11 re Strategic Planning

8) Report No. 040-11 re Review of US National Research Council Report: Fluoride in Drinking Water – A Scientific Review of EPA's Standards

9) Report No. 042-11 re Intensive Intervention for Smoking Cessation

10) Report No. 043-11 re Ready for School – Thames Valley Neighbourhood Early Learning Program

11) Report No. 044-11 re The Work of Public Health Nurses in Shelters

12) Report No. 045-11 re Nursing Practice Excellence

CONFIDENTIAL

13) That the Board of Health move into Committee of the Whole for the purpose of considering a matter pertaining to advice that is subject to Solicitor-Client privilege, including communications necessary for that purpose.

OTHER BUSINESS

Next Board of Health Meeting – Thursday, May 19, 2011, 7:00 PM

The Health Unit Volunteer Reception will be held prior to the May Board Meeting in the Middlesex Room (County Building) beginning at 4:45 pm.

CORRESPONDENCE RECEIVED

a) Dated 2011 February 11 (received 2011 March 9) Correspondence from The Honourable Deb Matthews, Ontario Minister of Health and Long-Term Care, re one-time funding of $20,800 to support the Health Unit's vaccine storage and handling program.

b) Dated 2011 March 14 (received 2011 March 14) Correspondence from Ms. Jean Lam, Assistant Deputy Minister, Ontario Ministry of Health Promotion and Sport, advising that the provincial government has committed one-time funding up to $85,000 for the South West Tobacco Control Area Network (TCAN) for the period of April 1, 2010 to March 31, 2011

c) Dated 2011 March 17 (received 2011 March 23) Correspondence from Ms. Julie Mathien, Director, Early Learning and Child Development Branch re approval of one-time funding to support province-wide training for staff of the Healthy Babies Healthy Children program.

d) Dated 2011 March 23 (received 2011 March 28) Correspondence from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Sudbury and District Health Unit, to The Honourable Deb Matthews, Ontario Minister of Health and Long-Term Care and The Honourable Margarett Best, Ontario Minister of Health Promotion and Sport, re: Sudbury and District Board of Health passing the following resolution:

WHEREAS energy drinks contain excess amounts of *caffeine, sugar and other additives; and*

WHEREAS energy drinks provide minimum nutritional value and children and youth consuming energy drinks may easily exceed the maximum amount of *caffeine for their age; and*

WHEREAS there are no regulations prohibiting the advertisement or sale of *energy drinks to children and youth; and*

WHEREAS the effects of *caffeine present in energy drinks can mask the symptoms* of *intoxication when energy drinks are mixed with alcohol and may lead to alcohol toxicity, impaired driving, and other negative outcomes; and*

WHEREAS Health Canada issued a *media advisory in May 2010 which expressed their concern over combinations* of *energy drinks and alcohol;*

THEREFORE BE IT RESOLVED THA T the Sudbury & *District Board of Health urge the federal Minister of Health, the provincial Minister of Health and Long-Term Care and Minister of Health Promotion and Sport to review the health issues associated with energy drinks, their advertisement to children and youth and their sale as premixed alcohol/energy drink beverages in liquor stores; and*

FURTHERMORE THAT copies of this motion be forwarded to all Ontario boards of health, provincial government partners and local members of provincial parliament, the Ontario Public Health Association (OPHA), the Association of Local Public Health Agencies (alPHa), Federation of Northern Ontario Municipalities (FONOM) and local school boards.

e) Dated 2011 March 23 (received 2011 March 28) Correspondence from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Sudbury and District Health Unit, to The Honourable Leona Aglukkaq, Minister of Health, re: Sudbury and District Board of Health passing the following resolution:

*WHEREAS e*nergy drinks contain excess amounts of caffeine, sugar and other additives; and

WHEREAS energy drinks provide minimum nutritional value and children and youth consuming energy drinks may easily exceed the maximum amount of caffeine for their age; and

WHEREAS there are no regulations prohibiting the advertisement or sale of energy drinks to children and youth; and

WHEREAS the effects of caffeine present in energy drinks can mask the symptoms of intoxication when energy drinks are mixed with alcohol and may lead to alcohol toxicity, impaired driving, and other negative outcomes; and

WHEREAS Health Canada issued a media advisory in May 2010 which expressed their concern over combinations of energy drinks and alcohol;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health urge the federal Minister of Health, the provincial Minister of Health and Long-Term Care and Minister of Health Promotion and Sport to review the health issues associated with energy drinks, their advertisement

to children and youth and their sale as premixed alcohol/energy drink beverages in liquor stores; and

FURTHERMORE THAT copies of this motion be forwarded to all Ontario boards of health, provincial government partners and local members of provincial parliament, the Ontario Public Health Association (OPHA), the Association of Local Public Health Agencies (alPHa), Federation of Northern Ontario Municipalities (FONOM) and local school boards.

Copies of all correspondence are available for perusal from the Secretary- Treasurer.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 035-011

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Two New Full Time Equivalent Public Health Nursing Positions

Recommendation

It is recommended that the Board of Health accept the Ministry of Health and Long-Term Care conditions as defined in Appendix B of Board of Health Report No. 035-11 to receive up to $170,040 to support two new full time equivalent Public Health Nursing positions.

Background

On Tuesday, March 15, 2011, electronic versions of letters to Ms. Patricia Coderre, Board of Health Chair and the Medical Officer of Health were received from the Ministry of Health and Long-Term Care (MOHLTC) announcing funding has been approved for this Health Unit to receive up to $170,040 to support two new full time equivalent (FTE) Public Health Nursing (PHN) positions (Appendices A and B). This is ongoing funding which is 100% funded by the MOHLTC.

The new positions are “to address the program and service needs of priority populations, including priority populations impacted most negatively by the determinants of health in the health unit area”. Examples provided include Aboriginal/First Nation populations, Francophone populations, low income families, or vulnerable populations affected by bed bug infestations. The new positions are intended to support Ontario’s Poverty Reduction Strategy as well as the MOHLTC Mental Health and Addiction Strategy and nursing recruitment/retention commitment.

Funding Requirements

There are a number of requirements related to the funding for the new positions, the first of which is the acceptance by the Board of Health of the MOHLTC terms and conditions defined in Appendix B. An Initial Project Report outlining the intended key achievements and activities related to the new positions must be forwarded to the Ministry no later than April 30, 2011. Subsequent Project Reports are required as per the schedule identified in Appendix B. The third requirement is provision of proof of employment for each new full time equivalent PHN. Only upon receipt of the latter documentation will funding be flowed by the MOHLTC.

Proposed Focus of Each New Position

Clarifying information regarding the criteria applicable to the new positions was not received until April 1, 2011(Appendix C). A Senior Management Team Working Group comprised of Mr. Wally Adams, Acting Director, Environmental Health and Chronic Disease Prevention Services; Ms. Diane Bewick, Director, Family Health Services; Ms. Louise Tyler, Director, Human Resources and Labour Relations; and

Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual Health Services has been struck to develop a proposed focus for each of the new positions. These proposals will be presented at the May Board of Health meeting. To initiate the funding approval process, it is recommended that the Board of Health acknowledge acceptance of the MOHLTC conditions.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

Appendix A

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
Fax 416-326-1571
www.health.gov.on.ca

Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

10e étage, édifice Hepburn
80, rue Grosvenor
Toronto ON M7A 2C4
Tél 416-327-4300
Téléc 416-326-1571
www.health.gov.on.ca

Ontario

MAR 0 8 2011

HLTC2976FL-2010-616

Ms. Patricia Coderre
Chair
Middlesex-London Board of Health
50 King Street
London ON N6A 5L7

Dear Ms. Coderre:

I am pleased to inform you that Middlesex-London Health Unit has been approved to receive new base funding of up to $170,040 (at 100%) starting January 1, 2011, to support two new Full-Time Equivalent (FTE) public health nursing positions. This investment is part of the 9,000 Nurses Commitment, a key component of the province's health human resources strategy, HealthForceOntario.

These Public Health Nurses are to help support priority populations impacted by determinants of health. Addressing the determinants of health is a key requirement of the Ontario Public Health Standards. This initiative also aligns with Ontario's Poverty Reduction Strategy, the Ministry's Mental Health and Addictions Strategy, and supports nursing recruitment/retention in the province.

In a subsequent letter, Ms. Allison J. Stuart, Assistant Deputy Minister, Public Health Division, Ministry of Health and Long-Term Care, will be writing to Dr. Graham Pollett, Medical Officer of Health, Middlesex-London Health Unit, with the accountability and administrative details regarding this funding.

The ministry wishes to take this opportunity to thank you for your continued commitment and dedication to promoting healthy living, preventing illness, injury and disease in your health unit area.

Sincerely,

Deb Matthews

Deb Matthews
Minister

c: Hon. Steve Peters, MPP, Elgin-Middlesex-London
Maria Van Bommel, MPP, Lambton-Kent-Middlesex

.../2

c: Hon. Christopher Bentley, MPP, London West
Khalil Ramal, MPP, London-Fanshawe
Dr. Graham Pollett, Medical Officer of Health, Middlesex-London Health Unit

Appendix B

Ontario

Ministry of Health and Long-Term Care

Assistant Deputy Minister

Public Health Division
5th Floor, Hepburn Block
Queen's Park
Toronto ON M7A 1R3

Telephone: (416) 325-8411
Facsimile: (416) 325-4670

Ministère de la Santé et des Soins de longue durée

Sous-ministre adjoint

Division de la santé publique
Édifice Hepburn, 5e étage
Queen's Park
Toronto ON M7A 1R3

Téléphone : (416) 325-8411
Télécopieur : (416) 325-4670

MAR 10 2011

Dr. Graham Pollett
Medical Officer of Health
Middlesex-London Health Unit
50 King Street
London ON N6A 5L7

Dear Dr. Pollett:

Further to the recent letter from the Honourable Deb Matthews approving new base funding of up to $170,040 (at 100%) starting January 1, 2011, I am writing to provide the accountability and administrative details. This funding will support salary and benefits related to two new Full Time Equivalent (FTE) public health nursing positions as part of the 9,000 Nurses Commitment, a key component of the province's health human resources strategy.

Public Health Nurses with specific knowledge and expertise will provide enhanced supports to address the program and service needs of priority populations, including priority populations impacted most negatively by the determinants of health in the health unit area. Addressing the determinants of health is a key requirement of the Ontario Public Health Standards. This initiative also aligns with Ontario's Poverty Reduction Strategy, the Ministry's Mental Health and Addictions Strategy, and supports nursing recruitment and retention in the province.

Please note that funding is subject to the following conditions:

- ✓ Funds must be used for the intended purpose (i.e. recruitment of two new public health nursing FTEs);
- ✓ Proof of offer of employment including starting salary level and benefits for each FTE; and
- ✓ Funding for these positions is subject to the 2010 Program-Based Grants Terms and Conditions.

Detailed criteria are set out in Appendix A including specifications for the recruitment of the Public Health Nurses and the Ministry of Health and Long-Term Care's reporting requirements.

Dr. Graham Pollett

In order to accept the conditions to receive this funding, please return a signed copy of Appendix B of this letter. In order to receive funding, we kindly ask that you submit the proof of employment to:

Jacky Sweetnam
Manager (A), Practice & Standards Unit
Public Health Practice Branch
Public Health Division
Ministry of Health and Long-Term Care
393 University Avenue, 21st Floor
Toronto ON M7A 2S1

As you are aware, Ontario has felt the effects of the global recession and is running a deficit in order to create jobs and protect public services. While the contributions of those who deliver public services are valued and appreciated, the public also expects those who are paid by tax dollars to do their part to help sustain public services.

The government has passed the Public Sector Compensation Restraint to Protect Public Services Act, 2010, which freezes compensation plans for all non-bargaining employees in the broader public sector, including the Ontario Public Service, for two years. For employees who bargain collectively, the government will respect all current collective agreements. When these agreements expire and new contracts are negotiated, the government will work with transfer payment partners and bargaining agents to seek agreements of at least two years' duration that do not include net compensation increases. The fiscal plan provides no funding for compensation increases for future collective agreements.

Funding provided by the province to transfer payment partners and agencies is for the purpose of providing and protecting public services and is not to be diverted to fund increases in employee compensation.

If you have any questions about this initiative please contact Jacky Sweetnam, Manager (A), Practice and Standards Unit, Public Health Practice Branch, Ministry of Health and Long-Term Care at jacky.sweetnam@ontario.ca or at (416) 314-1042.

Yours truly,

Allison J. Stuart
Assistant Deputy Minister

c: Dr. Arlene King, Chief Medical Officer of Health
Suzanne McGurn, Assistant Deputy Minister (A), Health Human Resources Strategy Division
Marilyn Wang, Interim Director, Nursing Secretariat
Pier Falotico, Director, Financial Management Branch, Corporate Services Division
Sylvia Shedden, Director, Public Health Practice Branch, Public Health Division

Appendix A

Project Description and Timelines

9,000 Nurses Commitment

The 9,000 Nurses Commitment is a workforce stabilization strategy that forms the cornerstone of Ontario's Comprehensive Nursing Strategy. This government platform commitment is a key component of the province's health human resources strategy, HealthForceOntario, which aims to ensure that Ontario has the right number and mix of qualified health care professionals now, and in the future.

Stabilizing the nursing workforce improves access to quality and safe care thereby contributing to improved patient outcomes and reducing the burden of illness and associated costs on the health care system. In addition, long-term savings and cost avoidance may be realized through the stabilization of the nursing workforce as turnover, overtime, and losses may be reduced.

The recipient is required to adhere to the 9,000 Nurses *Funding Accountability Principles* as follows:

- Funding from the 9,000 Nurses Commitment must be used for the creation of additional hours of nursing service (full-time equivalents);
- Boards of Health must commit to maintaining baseline nurse staffing levels and creating new nursing full-time equivalents (FTEs) above this baseline;
- Boards of Health will be required to report financial and statistical data to the ministry on various outcomes;
- Funding is for nursing salaries/benefits only and cannot be used to support operating or education costs; and
- Boards of Health must commit to maintenance of, and gains towards, the 70% full-time employment target for nurses.

Public Health Nurses (Priority Populations)

The two new Public Health Nurses with specific knowledge and expertise will provide enhanced supports to address the program and service needs of specific, and sometimes hard-to-reach, populations impacted most negatively by the determinants of health in their health unit area. These unique priority populations require targeted support and interventions and could include, but are not limited to: Aboriginal/First Nation populations, Francophone populations, low income families, or vulnerable populations affected by bed bug infestations. Public Health Nurses dedicated to working with unique priority populations will support Boards of Health in tackling the negative health impacts on those populations more aggressively and provide enhanced supports to, for example:

- Support the development of enhanced relationships with identified priority populations which requires substantial time, expertise and capacity to develop in order to maximize the effectiveness of public health programs and services in meeting their needs;
- Support the development of partnerships with other service providers and agencies within and outside of the health system.

Addressing the determinants of health is a key requirement of the Ontario Public Health Standards, which state that "population health outcomes are often influenced disproportionately by sub-populations who experience inequities in health status and comparatively less control over factors and conditions that promote, protect, or sustain their health". This initiative also aligns with Ontario's Poverty Reduction Strategy and the Ministry's Mental Health and Addictions Strategy.

Recruitment of the two Public Health Nurses must consider the following:

- Applicant must be a registered nurse.
- Applicant must have, or be committed to obtaining, the qualifications of a public health nurse as specified under the Health Protection and Promotion Act.
- Boards of Health are encouraged to accept applicants that have experience that reflects an understanding of the priority population's values, cultural beliefs, and social norms.
- Boards of Health are encouraged to accept applicants that have the knowledge and skills required to work with priority populations as identified by population health assessment and surveillance activities consistent with the Ontario Public Health Standards requirements.

Timelines

2 PHN FTEs will be created and implemented starting January 1, 2011 and sustained for funding year 2012 and beyond.

Funding and Reporting

Funding is being provided to support a salary and benefit level of up to $85,020 per FTE. Benefits should not exceed 24% of salary.

Funding is subject to the 2010 Program-Based Grants Terms and Conditions. Proof of employment of each new FTE must be provided to the Ministry of Health and Long-Term Care before new base funding can be flowed.

Further to Section 18 of the 2010 Program-Based Grants Terms and Conditions, the Ministry of Health and Long-Term Care (MOHLTC) requires that the Board of Health also prepare and submit to the MOHLTC the following reports, at the following times:

<u>For 2011 and all subsequent funding years</u>

Name of Report	For the Period Of	Due Date
Initial Project Report for 2011	January 1, 2011 to March 31, 2011	April 30, 2011
Subsequent Project Report for 2011	April 1 to December 31, 2011	January 31, 2012
Project Report for Subsequent Funding Years	January 1 to December 31	January 31 of each subsequent funding year

Other reports, as specified from time to time, by the Province upon reasonable notice.

Report Details

Initial/Annual Project Report (for each Funding Year) to include:

- Number of Public Health Nurses and FTEs.
- Key achievements and activities related to the Public Health Nurses.
- The impact of the Public Health Nurses on priority populations through the provision of programs and services.

Appendix B

Sign-Back Agreement for Board of Health

On behalf of the board of health, I acknowledge that our organization has been approved a total of up to $170,040 that is to be used for two Public Health Nurse FTEs under the 9,000 Nurses Commitment as identified in the accompanying Assistant Deputy Minister letter.

A signature from a representative who has the authority to bind the Board of Health for the Middlesex-London Health Unit is required below to indicate acceptance of the conditions as noted in Appendix A, and the funding letter. This funding will be subject to audit, report back and reconciliation.

Signature: _____

Name: _____

Board of Health: _____

Position: _____

Date: _____

Please return a signed copy of this form using one of the following methods:

By fax to: 416-314-7078, attention to Jacky Sweetnam; or
Scanned copy by email to: jacky.sweetnam@ontario.ca

Funding for Public Health Nursing Full Time Equivalents (FTEs)

Frequently Asked Questions

Section 1 – General

1. What does the funding for the new Public Health Nurse Full-Time Equivalents (FTEs) support?

This funding will support salaries and benefits for two new Public Health Nurse (PHN) FTEs per board of health as part of the 9,000 Nurses Commitment, a key component of the province's health human resources strategy.

The 9,000 Nurses Commitment is a workforce stabilization strategy that forms the cornerstone of Ontario's Comprehensive Nursing Strategy. This government platform commitment is a key component of the province's health human resources strategy, HealthForceOntario, which aims to ensure that Ontario has the right number and mix of qualified health care professionals now, and in the future.

2. Are the new PHNs required to provide any specific support or services?

Yes. The new PHN FTEs are intended to provide enhanced supports to address the program and service needs of specific populations impacted most negatively by the determinants of health in your catchment area, and identified by the board of health as priority populations.

3. What are the expected outcomes of the public health nurses funding?

- To enhance public health nursing capacity in Ontario's 36 Boards of Health;
- To enhance capacity to address the social determinants of health by recruiting PHNs with specific knowledge and expertise;
- To enhance supports to address the program and service needs of specific priority populations impacted most negatively by the determinants of health;
- To improve the stability of the nursing workforce; and
- To increase access to care and hours of nursing service.

Section 2 – Funding for the Public Health Nurse Full-Time Equivalents (FTEs)

4. How much funding is available for the 2 new PHN FTEs?

Annualized base funding of up to $85,020 per FTE for salaries and benefits (at 100%). This was based on the mid-salary of public health nurses across the province.

5. How much is to be provided for benefits?

Benefits should not exceed 24% of salary.

6. **What if the benefits in our collective agreement at the board of health exceed 24%?**

   Benefits cannot exceed 24% of salary under this funding specifically; however, boards of health may wish to fund the difference between the 24% benefit level under this initiative and benefit levels under existing collective agreements separately.

7. **Our board of health may not be able to recruit an FTE at the salary and benefit level being provided. How was the salary and benefit level of $85,020 established for this initiative?**

   $85,020 is a mid-range salary for PHNs in Ontario based on sector appropriate hourly wages and a 24% benefits rate.

   Each board of health in Ontario has received the same funding level for the PHN FTEs. The ministry anticipates that boards of health will make their best effort to hire 2 PHN FTEs and support increased full-time nursing employment in the public health sector.

8. **Is the funding subject to any conditions?**

   Yes. Funding is subject to the following conditions:

   - Funds must be used for the intended purpose (i.e. recruitment of two new public health nursing FTEs), and to address the program and service needs of specific, and sometimes hard-to-reach, populations impacted most negatively by the determinants of health in their health unit area;
   - Proof of offer of employment including starting salary level and benefits for each FTE, which should **not** include any personal or identifiable information related to the nurse recruit (see attached); and
   - Funding for these positions is subject to the 2010 Program-Based Grants Terms and Conditions.
   - Must reflect an overall increase to the number of nurses employed by the phu

9. **In the administrative letter sent on March 10, 2011, Appendix A included a statement that "boards of health must commit to maintenance of, and gains towards, the 70% full-time employment target for nurses", what does this mean?**

   A key government platform commitment is to move towards 70% of nurses working full-time in Ontario. This movement promotes enhanced continuity of care, improved patient outcomes, intra and inter professional collaboration, retention and recruitment of nurses, sustainability of the nursing workforce, and system cost-effectiveness. It is our understanding that most health units employ most of their nurses on a full-time basis so this requirement may not be as relevant in the public health sector.

10. **When can the board of health expect to receive the new base funding for the 2 PHN FTEs?**

    The board of health must provide proof of offer of employment and sign back of Appendix B (see letter from Allison J. Stuart dated March 10, 2011) to the Ministry of Health and Long-Term Care in order to receive funding under this initiative. The proof of offer of employment should **not** include any personal or identifiable information related to the nurse recruit (see attached).

11. When should the board of health submit the sign back of Appendix B to the Ministry?

The sign back to terms and conditions of the funding can be submitted before proof of offer of employment is submitted to the Ministry. However, sign back of the terms and conditions and proof of offer of employment are both required before funding will be provided to a board of health.

12. Is the board of health required to hire both FTEs at the same time in order to receive any of the funding?

No. The FTEs can be hired at different times.

13. What detail is required with the proof of offer of employment?

The following information is required as part of the proof of offer of employment:

- The FTE amount for each position
- The salary level and benefits for each position
- The start date of the new hire

Please note that the proof of offer of employment should **not** include any personal or identifiable information related to the nurse recruit (see attached).

14. Is there a standard form or template within which to provide the details required for the proof of offer of employment?

A standard form is being provided to accompany these FAQs.

15. Does the new recruit have to be hired as a 1.0 FTE?

This funding must support the creation of two 1.0 FTEs in each health unit. Health units can hire more than one **permanent** PHN to fill a 1.0 FTE (e.g. 0.5 FTE + 0.5 FTE = 1.0 FTE). However, the salary and benefits of each PHN FTE will not be funded beyond $85,020 per FTE.

Health Units can hire a partial FTE under this funding only if there is a commitment to reach the full FTE target for each position.

16. Can any of the funding be used for other operational costs (e.g. staff training, travel, office expenses, etc)?

No. The funding is to be used for salary and benefits only.

Section 3 – Recruitment of a PHN FTE under this funding

17. Can current nursing positions at the board of health be funded under this initiative? (e.g. must a board advertise externally for positions or can it appoint a qualified PHN from within the board of health?)

Funding for the Public Health Nurses is meant to generate new nursing hours dedicated to enhancing supports and services to priority populations impacted most negatively by the determinants of health. The board of health should be able to demonstrate that two PHN

FTEs have been created and filled appropriately. As such, a board of health cannot use existing staff members to perform the functions of the two PHN FTEs in addition to their normal duties. However, a nurse currently working within the board of health and with appropriate qualifications (or a commitment to obtain the qualifications) could be hired or placed in the new role created under this funding if another nurse is hired and assigned to the existing role as appropriate. This would increase the number of hours of nursing service under this initiative.

18. Does the new recruit have to be a Public Health Nurse or can the new recruit be a Nurse Practitioner for example, as long as the board of health can demonstrate that the position will address the program and service needs of priority populations impacted most negatively by the determinants of health?

The funding is intended for qualified Public Health Nurses or a nurse recruit that is, or is committed to, obtaining the qualifications to be a qualified public health nurse as specified under the Health Protection and Promotion Act.

Section 4 – Reporting Requirements

19. Are there any reporting requirements for these PHN FTEs?

Yes. Boards of health will be required to submit financial reports required under the 2010 Program-Based Grants Terms and Conditions (e.g. quarterly and settlement reports). Boards of health will also be required to submit initial annual/project reports. Please see Appendix A of the administrative letter from Allison J. Stuart dated March 10th 2011 for the details of the reporting requirements. Please also see questions 20-22 below.

20. What should be included in the Initial /Annual Project Reports?

- Number of Public Health Nurses and FTEs.
- Key achievements and activities related to the Public Health Nurses.
- The impact of the Public Health Nurses on priority populations through the provision of programs and services.

21. Is there a standard form or template within which to provide the information required in the Initial/Annual Project Reports?

The ministry will provide a template to boards of health.

22. What are the deadlines for the Initial /Annual Project Reports?

The table below includes the required reports and associated deadlines that were included in the March 10, 2011 administrative letter.

Name of Report	For the Period Of	Due Date
Project Report for 2011	April 1 to December 31, 2011	January 31, 2012
Project Report for Subsequent Funding Years	January 1 to December 31	January 31 of each subsequent funding year

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 036-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Call for Action Against Smoking in Movies

Recommendation

It is recommended:

1. That the Board of Health endorse the Ontario Coalition for Smoke-free Movies policies highlighted in Appendix A to Report No. 036-11; and further,
2. That the Board of Health communicate its support for policy actions to reduce the impact of smoking in movies on youth to local MPPs and other Boards of Health in Ontario.

Background

The Ontario Coalition for Smoke-Free Movies was formed in May 2010 to take collective action to counter the harmful impact of smoking in movies. Members of the Ontario Coalition for Smoke-free Movies include the Canadian Cancer Society - Ontario Division, Heart and Stroke Foundation of Ontario, Non-Smokers' Rights Association/Smoking and Health Action Foundation, Ontario Lung Association, Ottawa Public Health Exposé, Physicians for a Smoke-Free Canada, Program Training and Consultation Centre Media Network and Ontario Tobacco Control Area Networks (TCAN). The Middlesex-London Health Unit is the host of the southwest TCAN.

Research has shown that the more youth see smoking in movies, the more likely they are to start. In 2009, Canadian theatres delivered over 1.1 billion tobacco impressions in youth-rated films alone. It is important to note that since movies are also viewed on DVD and Blue-ray, video-on-demand, cable, satellite, broadcast and broadband media, 1.1 billion underestimates the total tobacco impressions viewed in youth-rated films.

Immediate Action is Required

Tobacco imagery in movies and in video games is a powerful vehicle for promoting tobacco. Since the November 1998 Master Settlement Agreement in the United States, attention has been drawn to the links between Hollywood and the Tobacco Industry, including evidence of payments for tobacco product placement in movies and industry files that show the role of movies in tobacco promotion. One letter states: "Film is better than any commercial that has been run on television or in any magazine, because the audience is totally unaware of any sponsor involvement."

Extensive research on the effects of smoking and other tobacco portrayals in films demonstrates a relationship between smoking in the movies and youth tobacco initiation. According to the Tobacco Vector Report, created by the Physicians for a Smoke-free Canada, latest research suggests 44% of the estimated 300,000 Canadian teens who smoke, first lit up because they saw a character smoking in a film (about 130,000 of youth 15-19). Since provincial rating agencies (Ontario Film Review Board) seldom apply adult ratings (18A) to top-grossing films rated "R" in the United States, Ontario children and youth are exposed to an estimated 60 percent more tobacco imagery than their US counterparts. This influence is compounded by the fact that generally smoking is glamorized on film, and rarely are the negative health effects of using tobacco products shown.

Recent data on youth and young adult tobacco-use rates suggest that declines in tobacco use have halted. According to the 2009 Ontario Student Drug Use and Health Survey, 16% of youth in grades 9 to 12 in southwestern Ontario reported past year cigarette smoking, and 7.5% reported daily smoking.

Call for Action

The Ontario Coalition for Smoke-Free Movies is calling for health organizations and agencies that work with children and youth to endorse the policies outlined on page two of Appendix A to reduce youth exposure to on-screen smoking and impressions of tobacco.

Conclusion

Tobacco use remains the number one cause of preventable disease and death in Ontario. Smoking in movies challenges Ontario's tobacco control efforts. Tobacco imagery in movies, particularly films rated as suitable for children and adolescents, promotes tobacco use and normalizes tobacco products to

youth. Endorsement of the Ontario Coalition for Smoke-free Movies policy actions would help to prevent young people from starting to use tobacco products.

The Ontario Coalition for Smoke-Free Movies encourages Board of Health members, public health professionals, parents and education leaders to visit www.smokefreemovies.ca to learn more and contribute to this movement.

This report was prepared by Ms. Amy Yateman, Health Promoter, and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team. Ms. Stobo will be present at the April 14 Board of Health meeting to answer any questions.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Comprehensive Tobacco Control; 1, 7, 11

ONTARIO COALITION FOR SMOKE-FREE MOVIES

September 1, 2010

Dear colleague,

Re: Act now to reduce the impact of smoking in movies on youth in Ontario

As you are aware, tobacco use is the number one cause of preventable disease and death in Ontario. The 2008 review of tobacco and media by the US National Cancer Institute (*Monograph 19*) reached an unequivocal conclusion regarding the impact of smoking in movies on youth tobacco use: "The total weight of evidence from cross-sectional, longitudinal and experimental studies indicates a causal relationship between exposure to smoking in movies and youth smoking initiation."

Researchers estimate that 44% of youth smoking can be attributed to exposure to on-screen smoking. The influence of movie smoking on young people should not be surprising, given the pervasive influence of Hollywood on popular culture and the fact that most other vehicles of tobacco promotion have been banned in Canada.

The tobacco industry's collaboration with Hollywood, including paid product placement, is well documented. The tobacco industry's own files reveal the importance of movies to tobacco promotion: "Film is better than any commercial that has been run on television or in any magazine, because the audience is totally unaware of any sponsor involvement."

The World Health Organization recommends four solutions to reduce tobacco depictions in movies. The recent report *Tobacco Vector*, commissioned by Physicians for a Smoke-Free Canada, examines the importance of applying these policy solutions in Canada, as well as the role of public funding and film subsidies for youth-rated films with tobacco depictions.

Smoking in movies undermines our collective tobacco control efforts. We encourage you to support the policy actions needed to reduce the impact of smoking in movies on youth initiation and subsequent long-term addiction to tobacco industry products. Please submit a letter of endorsement to the Ontario Coalition for Smoke-Free Movies to John Atkinson at jatkinson@on.lung.ca. Endorsements are being compiled online by the Ontario Lung Association's Youth Advocacy Training Institute at www.smokefreemovies.ca.

A sample statement of endorsement is enclosed for your consideration and signature along with a summary of the evidence with references in the fact sheet *Smoking in the Movies*.

Sincerely,

Lorraine Fry
lfry@nsra-adnf.ca

Andrea Kita
andrea.kita@hamilton.ca

Co-chairs, Ontario Coalition for Smoke-Free Movies

ENDORSEMENT OF ACTION ON SMOKING IN MOVIES

Tobacco use is the number one cause of preventable disease and death in Ontario. Leaders in public health units, local boards of health, non-governmental organizations and health charities in Ontario have a history of speaking out in favour of actions to reduce the harmful impact of tobacco use.

Whereas tobacco use is the leading cause of preventable death and disability in Canada, accounting for the deaths of approximately 13,000 people in Ontario alone each year;[1]

Whereas the tobacco industry has a long, well-documented history of promoting tobacco use and particular brands on-screen, while obscuring its true purpose in doing so;[2]

Whereas adolescents watch more films than any other age group: movie-going is a universal experience and tobacco imagery in films is currently unavoidable;[3]

Whereas nearly 90 percent of tobacco impressions delivered to theatre audiences in Canada in 2009 were delivered by large US media conglomerates; [3]

Whereas Canadian movie rating systems classify more movies as 14A or PG that are rated R in the US resulting in 60% more tobacco imagery exposure by youth-rated films;[3]

Whereas exposure to smoking in movies is estimated to be responsible for 44% of youth uptake;[4]

Whereas an estimated 130,000 Canadian smokers aged 15-19 have been recruited to smoke by exposure to on-screen smoking, and 43,000 of them will eventually die of tobacco-caused diseases;[3]

Whereas the World Health Organization has advised all nations that have ratified the *Framework Convention on Tobacco Control*, a global treaty obligating Parties including Canada to prevent youth smoking and end tobacco promotion through all channels, to give an adult rating to all new films that depict smoking, whether domestically produced or imported;[5]

Therefore be it resolved that _____ (name of organization) **endorses the following policies to reduce the exposure of youth to smoking in movies:**

(1) Rate new movies with smoking "18A" in Ontario, with the sole exceptions being when the tobacco presentation clearly and unambiguously reflects the dangers and consequences of tobacco use or is necessary to represent smoking of a real historical figure.

(2) Require producers to certify on-screen that no one involved in the production of the movie received anything of value in consideration for using or displaying tobacco.

(3) Require strong anti-smoking ads to be shown before any movie with tobacco use at the distributor's expense, regardless of rating and distribution channel.

(4) Require producers to stop identifying tobacco brands.

(5) Require that films with tobacco imagery assigned a G, PG, or 14A rating be ineligible for federal and provincial film subsidies.

Signed _____ Date _____

[1] http://www.mhp.gov.on.ca/en/smoke-free/default.asp Accessed August 17 2010
[2] C Mekemson and SA Glantz, "How the tobacco industry built its relationship with Hollywood," *Tobacco Control* 2002; 11: i81-i91. KL Lum, JR Polansky, RK Jackler, et al., *Tobacco Control* 2008; 17: 313-323.
[3] Polansky, J.. Tobacco Vector: How American movies, Canadian film subsidies and provincial rating practices will kill 43,000 Canadian teen alive today- and what Canadian government scan do about it. Physicians for Smoke-Free Canada. July 2010.Accessed August 2010 www.smoke-free.ca/pdf_1/2010/Tobaccovector.pdf
[4] C Millett and SA Glantz, "Assigning an '18' rating to movies with tobacco imagery is essential to reduce youth smoking (editorial)," *Thorax* 2010; 65(5): 377-78
[5] World Health Organization, *Smoke-free movies: From evidence to action*, 2009.Accessed April 2010 http://www.who.int/tobacco/smoke_free_movies/en/

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 037-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Records and Information Management Program – Revised Policy 6-030

Recommendation
It is recommended that the Board of Health approve revised Policy 6-030 – Health Unit Records-Establishment, Record Classification, Retention and Disposal.

Background
The Ontario Public Health Organizational Standards released in March 2011 require that the Board of Health ensures the Medical Officer of Health establishes, maintains and implements policies and procedures related to records management, including an appropriate records retention process (that varies by the type of record) and the secure disposal of records.

Revised Policy 6-030
Following the Board of Health's approval in January 2011 of retention periods for Health Unit records (Report 004-11), Policy 6-030 was revised. It now includes a new Records Classification System and a revised Retention Schedule as Schedule A (Appendix A). The Classification System groups Health Unit records into standard categories to be used to file both paper and electronic records. The Retention Schedule specifies the length of time records must be retained and the method of disposal. The Classification System/Retention Schedule is considered one document and foundational to a Records and Information Management Program.

The revised policy provides an overview of the Health Unit Records and Information Management Program and includes procedures related to operationalizing the Classification System/Retention Schedule, roles and responsibilities, on-site and off-site record storage, archiving, record disposal and continuous quality assurance measures. Schedule A is considered an evergreen document as it is not static; it is anticipated that as the Classification System/Retention Schedule is implemented across the Health Unit, continuous quality improvement initiatives and routine monitoring will result in periodic revisions.

Progress to Date and Next Steps
Training about Records and Information Management has begun. With the approval of the retention periods, staff members have been reviewing records and purging those that have met the required retention periods; making upgrades to the secure access 50 King Street Records Room; initiating steps to protect archival records; initiating training and implementing use of a secure on-line system which allows each Service Area to manage its off-site records.

Standardizing how paper and electronic records are filed represents a significant milestone in the Records and Information Management Program and a major change for all staff. Successful implementation will require substantial training across the Health Unit and time to implement on a go forward basis.

The Manager, Special Projects (Records Management and Accreditation), will play a key role in implementing the policy and the use of standardized classifications. Recruitment is underway and an update will be provided at the Board meeting.

This report was prepared by Ms. Charlene Beynon, Manager, Special Projects, Office of the Medical Officer of Health.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Organizational Standards (2011): Item 6.12 Information Management.

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: **Health Unit Records – Establishment, Record Classification, Retention and Disposal**

POLICY NUMBER: 6-030

SECTION: Records Management

Page 1 of 9

IMPLEMENTATION DATE: March 23, 1993
REVISION DATE: October 12, 1995,
October 16, 1997
May 25, 2000
XX / XX / XXXX

APPROVED BY: Board of Health
SIGNATURE:

Table of Contents

PURPOSE

To ensure that the Health Unit has a Records & Information Management Program that is compliant with legislation and consistent with best practices.

POLICY

This policy applies to paper and electronic records, including email.

Records provide evidence of how the Health Unit conducts business and may be in any format including paper, electronic, audio or video media, photographs, maps etc.

Records and information are corporate assets and Records and Information Management is a core corporate function, essential to the work of the Health Unit.

Records are retained for as long as they retain administrative, fiscal, legal or historical value. Records deemed to have historical value will become part of the archival collection.

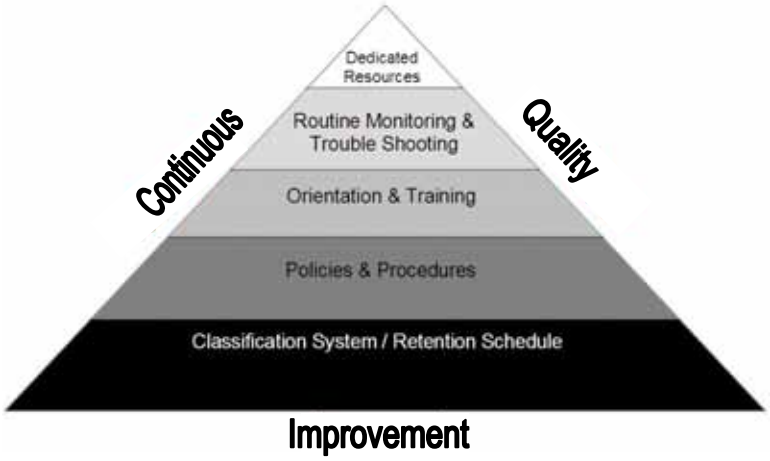
Records created or received by Board members and employees in the course of normal duties on behalf of the Health Unit are the property of MLHU.

MLHU has two types of records. Administrative records document activities related to MLHU staff and operations and client records document employee interactions with clients.

The goals of the R&IMP are to:

- ensure compliance with legislative requirements
- avoid premature disposal of records
- expedite the retrieval of needed information
- limit unnecessary accumulation of records
- promote cost-effective use of space and storage facilities, and
- assist in identifying and preserving records of historical value.

The Records and Information Management Program (R&IMP) consists of the following components:



A successful program is dependent on the engagement of all staff.

The Classification System/Retention Schedule (see Schedule A) is the foundational document for a Records and Information Management Program. The Classification System groups Health Unit records into standard categories which are used to file both paper and electronic records. The Retention Schedule specifies the length of time records must be retained and the method of disposal. The Classification System/Retention Schedule is considered one document and is approved by the Board of Health.

In order to be considered valid during litigation or when responding to a Freedom of Information (FOI) request, the Classification System/Retention Schedule must be used and interpreted consistently across the Health Unit.

The retention periods are mandatory unless there are extenuating circumstances or records are subject to FOI requests or legal action.

Record and Information Management implications should be considered when changes are being planned (e.g. introduction of new information and communication technology systems, organizational restructuring or major changes) to ensure that there is a record steward for records affected by the change and to avoid loss of information.

Procedure

1.0 Establishment of Records

1.1 Records are established for the purposes of documenting Health Unit operations and service activities. The need for a record may arise from policy directives, the Health Protection and Promotion Act, other legislation, professional codes of practice and/or accreditation standards.

1.2 Printed record forms must contain a unique identifier which will be used for classification and inventory control purposes. Directors or designates develop and apply the unique identifier system to service forms. The identifier must contain sufficient information to locate the document and verify version currency.

2.0 Classification System/ Record Retention Schedule (See Schedule A and Appendix A: Interpreting the Classification System/Retention Schedule)

2.1 The Classification System is used to file paper and electronic records.

- All records must be filed according to the Classification System under a primary heading and a secondary heading**.**
- The primary headings (e.g. Accounting (AC), Administrative (AD) etc.) and secondary headings (e.g. AD 01, AD 02 etc.) are standardized and are selected based on the document to be classified.

- **"**General" may be used if no other record series is suitable; however this category should be used infrequently.
- Additional primary and secondary headings must not be inserted into the Classification System/Retention Schedule.
- If a suitable category cannot be identified, the staff member is to consult their Manager. The Manager, Special Projects (Records Management & Accreditation) is available for consultation.
- The scope notes provide a brief description of what types of records are included under each heading.
- Examples are provided of the types of records which are included and those that are excluded and classified under other categories. The examples are intended to provide direction and do not list every possible record.
- The inclusion list may be used to label file folders/electronic files under the secondary headings.
- The groupings of records i.e. records series and the retention periods will be reviewed annually to ensure that the Classification System/Retention Schedule offers a good fit for Health Unit records. Based on the review and how the "General" classification is being used, additional categories may be added, while others may be removed.

2.2 The Classification System/Retention Schedule specifies the service/program responsible for the "official" record i.e. the Record Steward. Official records must be kept for the designated retention period. Other records which have short-term usefulness are considered "transitory" and may be disposed once they have served their purpose. If there is a FOI request or legal action, both official and transitory records must be retained. (See Appendix B for definitions of official and transitory records).

2.3 If justification can be made to classify a record under more than one category, the category that offers the best fit should be selected. The Record Steward i.e. the Service/Program responsible for the record will determine which classification will be used.

2.4 Retention periods are based on legislative requirements and where there are no requirements are based on best practices. Retention periods are broken down into active, inactive and total retention – see Appendix A – for definition of terms and retention codes; see Appendix C-Citation Tables; see 7.0 for disposing of records.

2.5 If an email meets the criteria to be considered an official record (See Appendix B), the email must be retained according to the required retention period. The email may be either saved electronically or printed. Transitory emails (See Appendix B) should be deleted and "emptied from the trash" when the email has served its short- term purpose. Appendix C which will address issues related to email will be developed.

2.6 Records involved in litigation must be retained in their original form until the litigation issues have been resolved.

3.0 Roles and Responsibilities

3.1 All staff including casual and short-term contract staff and students

- at the beginning of each year review records for action required according to the retention periods
- file and manage records according to the Classification System/Retention Schedule
- are familiar with Health Unit Records and Information Management policies and procedures
- attend required training sessions
- routinely review electronic and paper records and purge transitory materials e.g. early drafts that have been updated, duplicate copies etc
- review paper and electronic records for necessary action prior to leaving current assignment or MLHU.

3.2 Administrative Staff

- provide assistance to ensure team /program/ service records are classified according to the Classification System/Retention Schedule and retention periods are followed
- prepare paper records for storage in the Health Unit Records Room and for off-site storage (See Appendix D: Tips for Packing Boxes)
- advise the Manager, Special Projects (Records Management & Accreditation) of issues related to the Classification System/Retention Schedule
- assist the Manager, Special Projects (Records Management & Accreditation) in implementing the Records & Information Management Program
- Only Administrative Staff designated by their Director will have access to the Health Unit Records Room – see Section 4.0.

3.3 Directors and Managers

- ensure staff attend required training
- advise the Manager, Special Projects (Records Management & Accreditation) of any changes to program functions that may affect records or record-keeping practices
- consult with the Manager, Special Projects (Records Management & Accreditation) on issues related to the Records and Information Management Program
- ensure that the Classification System/Retention Schedule is implemented as intended
- provide necessary follow-up when monitoring identifies issues
- advise the Manager, Special Projects (Records Management & Accreditation) of any unauthorized destruction of records
- sign-off on forms authorizing the destruction of records (See Appendix G: Decision Path & Required Authorization for Record Disposal)
- Directors will notify the Manager, Special Projects (Records Management & Accreditation) of changes for staff access to the Health Unit Records Room
- Directors will ensure that Service Area specific records and information management policies and procedures are consistent with this policy.

3.4 Records and Information Management Program Advisory Committee

- recommend strategic directions,
- anticipate potential challenges and identify needed courses of action
- critique work plans/resource materials, and
- provide expert input to Manager, Special Projects (Records Management & Accreditation) on issues related to building, operating and sustaining a Records & Information Management Program.

For Terms of Reference –see Appendix H

3.5 Manager, Special Projects (Records Management & Accreditation)

- manages the overall functioning and day to day operations of the Records & Information Management Program
- works with Service Areas to determine what records are kept and how they should be kept
- provides reminders to staff and managers to review their records
- develops, implements and updates policies and procedures
- oversees the application of the Classification System/Retention Schedule
- recommends new or revised classification codes and retention requirements to Directors Committee
- provides consultation to staff
- conducts quality assurance checks and routing monitoring to ensure that the Classification System/ Retention Schedule is being implemented as designed, determines if modifications are required, and provides feedback to Service Areas
- provides input to IT re electronic document management systems to create and hold records
- provides orientation for new staff , ongoing training and training for on-line data entry for off-site storage
- disseminates material to promote record and information management best practices e.g. updates, postings on the intranet, newsletters, presentations at staff meetings
- prepares an annual report for Directors Committee
- approves the purchase of filing cabinets and recommends preferred filing equipment e.g. type of file folders
- chairs the Records & Information Management Program Advisory Committee
- participates in relevant professional associations e.g. ARMA (Association of Records Managers and Administrators).

3.6 Lead Responsibility

The Medical Officer of Health is considered the program champion. The champion ensures organizational commitment, required resources are available and needed action is taken when problems arise.

4.0 Health Unit Records Room- located on the lower level

4.1 This room is intended to store only records: 1) during the "inactive" retention period; 2) until records are sent to off-site storage; or 3) until records are destroyed. The Records Room may also be used to store records for part of the "active" retention period if the records are required infrequently by the involved Service Area.

4.2 Access is by card swipe and is restricted to a few individuals, identified by Service Area Directors.

4.3 Each Service Area has assigned space. If more or less space is required, the Manager, Special Projects (Records Management & Accreditation) is to be contacted.

4.4 Only standardized boxes i.e. approximately 15 ¼" L x 12 ½" W x 10" H (38.7 cm x 31.8 cm x 25.4 cm) with lids are to be used. The boxes may be obtained by emailing "Operations".

5.0 Archival Collection

5.1 When the retention period has been met, records identified by "AR" on the Classification System/ Retention Schedule will be reviewed by the involved Manager/ Director in consultation with the Manager, Special Projects (Records Management & Accreditation) to determine their archival value (see Appendix F-Criteria to Determine Archival Value). Such records must be considered to have enduring/permanent value and contain information about the Health Unit's history, organization, structure or functions. Examples include significant contracts, organizational changes, memorabilia, and photographs. Typically, a small number of records meet the criteria i.e. 2-5%. (See 6.0 Role of Health Unit Library regarding landmark public health reports and in-house publications).

5.2 Items must have significant accompanying information to make their value meaningful. When retaining material that requires a device for accessing, the necessary equipment must also be retained.

6.0 Role of the Health Unit Library

Published works are not records. The library is the repository for materials that have been published, i.e. books, journals, government reports and in-house research and evaluation reports. Such in-house reports should not be stored in the Records Room, in off-site storage, or in shared drives.

7.0 Disposal (See Appendix G: Decision Path & Required Authorization for Record Disposal)

7.1 Paper Records

- Documentation is required to track the authorization for and the subsequent disposal of records.
- Records that contain confidential, personal or personal health information must be placed in the locked gray bins designated for confidential shredding. A certified external contractor shreds the confidential documents on site and provides a "Certificate of Destruction" which includes the date, time, location, method of destruction, and signature of the operator. The documents are shredded so that they cannot be reassembled.
- Obsolete stationery, blank forms and letterhead, business cards that could be potentially misused should also be placed in the locked gray bins.
- If a document is highly confidential/sensitive, additional precautions may be warranted. e.g. staff member oversees the shredding.
- The document should not be manually torn before putting the document into the bin as this makes it more difficult to shred.
- Other records may be recycled by placing them in the large blue recycling bins.

  When in doubt, treat the document as confidential and use the gray bins designated for confidential shredding.

7.2 Electronic Records

- Documentation is required to track the authorization for and the subsequent disposal of records.
- When electronic files have reached the end of their retention period, which will be determined by the date on the file and with the required authorization (See Appendix G: Decision Path & Required Authorization for Record Disposal), the files must be deleted from the staff member's directory ensuring all versions i.e. duplicates, drafts etc are deleted from folders, disks, laptops and other portable computing devices. Note that database applications (such as Ministry and other applications) may not provide a capability for identifying or deleting records beyond their retention periods.

7.3 CD's, Floppy Diskettes, Audio and Video Media

- A locked bin will be provided in IT for the above media to be confidentially destroyed by the certified external contractor. A "Certificate of Destruction" will be provided.

8.0 Off- Site Storage

8.1 Off-site storage is provided by a contracted party.

8.2 Designated staff in each Service Area have individualized passwords to access an on-line database managed by the contractor for off-site storage. Such access will allow designated staff to securely manage on-line their Service Area's off-site records. Off-site holdings can be searched, boxes/ files added, retrieved, arrangements made to have boxes picked up or to

have box(es) or files delivered from Command Services. Pick-up and delivery are available for all Health Unit office locations.

8.3 Box descriptions should be sufficient to allow someone unfamiliar with the contents to know what is included.

8.4 Each box requires a barcode, which can be obtained by emailing “Operations”.

8.5 The designated staff have access only to their Service Area records and are expected to monitor these records regarding their retention periods. The Manager, Special Projects (Records Management & Accreditation) and designated administrative support have access to the full list of holdings.

8.6 The Manager, Special Projects (Records Management & Accreditation) will send reminders to the designated staff to review off-site holdings for records approaching their required retention period.

8.7 No records stored off-site may be destroyed without the prior authorization of the involved Director and Manager (See Appendix G: Decision Path & Required Authorization for Record Disposal).

9.0 Quality Assurance and Routine Monitoring

9.1 The Manager, Special Projects (Records Management & Accreditation) is expected to audit paper and electronic Service Area records to ensure that the Classification System/Retention Schedule is being implemented as intended, make recommendations and work with Service Areas to identify and address areas needing improvement.

9.2 The Service Area Manager/Director is expected to follow-up the areas noted with consultation and assistance as needed from the Manager, Special Projects (Records Management & Accreditation).

9.3 The results of the audits will be used to identify if new classifications are required, scope notes/descriptions need to be modified to better describe the types of records to be included in a records series and to identify if additional or refresher training is required .

References:

Ontario Council on Community Health Accreditation (2009) Accreditation Principles, Standards and Components.

Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c.M.sb

Health Protection and Promotion Act, R.S.O. 1990, c.H.7.

Regulated Health Professions Act, 1991

Ontario Public Health Organizational Standards (2011)

MIDDLESEX-LONDON HEALTH UNIT

Draft Classification System / Retention Schedule

April 1, 2011
Schedule A
Policy 6-030

Accounting – see pg 3

AC 01 Accounting General
AC 02 Accounts Payable
AC 03 Accounts Receivable
AC 04 Audits & Auditing
AC 05 Banking
AC 06 Budgeting
AC 07 Financial Statements
AC 08 Financial Reporting
AC 09 General Ledger Accounting
AC 10 Grant Funding
AC 11 Insurance
AC 12 Inventory Asset Management
AC 13 Payroll Administration
AC 14 Pension Records
AC 15 Purchasing
AC 16 Taxation

Administrative – see pg 10

AD 01 Administrative General
AD 02 Appreciation & Complaints
AD 03 Committees, Meetings, Agencies, Groups & Task Forces
AD 04 Conferences
AD 05 Consultants & Contractors
AD 06 Court Filings
AD 07 Mail & Courier Services
AD 08 Membership Administration
AD 09 Operational & Program Planning
AD 10 Policies, Procedures, Manuals & Guidelines Administration
AD 11 Corporate Project Management
AD 12 Records Management
AD 13 Travel Administration
AD 14 Vendors & Suppliers
AD 15 Visits & Tours

Building Services – see pg 19

BU 01 Building General
BU 02 Property Management
BU 03 Building Security
BU 04 Building Systems & Equipment Testing
BU 05 Parking
BU 06 Equipment Leases

Communications – see pg 22

CM 01 Communications General
CM 02 MLHU website
CM 03 Annual Report
CM 04 Graphic Standards
CM 05 Media
CM 06 Newsletters
CM 07 Promotional & Educational Materials
CM 08 Translation Inventory & Related Documents
CM 09 Health@mlhu.on.ca

Corporate – see pg 29

CR 01 Corporate General
CR 02 Accreditation
CR 03 Acts, Legislation& Regulations Administration
CR 04 Freedom of Information & Protection of Privacy
CR 05 Board of Health Committee & Standing Committees of the Board
CR 06 Board Membership
CR 07 Contracts, Agreement & Leases Management
CR 08 Corporate Document Management
CR 09 Copyrights & Trademark Administration
CR 10 Library Services
CR 11 Development Projects

Human Resources – see pg 36

HR 01 Human Resources General
HR 02 Attendance Management
HR 03 Benefits Administration
HR 04 Compensation Management
HR 05 Labour Relations
HR 06 Occupational Health & Safety
HR 07 Organizational Structure & Functions
HR 08 Personnel Files
HR 09 Recruitment
HR 10 Staff Recognition
HR 11 Orientation & Staff Development/Training
HR 12 Volunteer Program
HR 13 Volunteer Screening & Orientation
HR 14 Student Placement Program
HR 15 Education Services-Post-Secondary Institutions

Information Technology – see pg 47

IT 01 Information Technology General
IT 02 Applications
IT 03 Infrastructure
IT 04 Security Management
IT 05 Support & Operations

Programs & Services* - see pg 51

CF 01-07 Client Files
CDI 01-15 Chronic Diseases & Injuries
FH 01-19 Family Health
ID 01-11 Infectious Diseases
EH 01-09 Environmental Health
EP 01-07 Emergency Preparedness

* Based on Ontario Public Health Standards (OPHS).

Source: Sudbury & District Health Unit – November 19, 2010 Modified with permission. – Retention periods approved by MLHU Board of Health January 20, 2011

Client Files (CF) – page 51

	Chronic Diseases & Injuries CDI	Family Health FH	Infectious Diseases ID	Environmental Health EH	Emergency Preparedness EP
CF 01 Community as Client	✓	✓	✓	✓	
CF 02 Client Records	✓	✓	✓	✓	
CF 03 Hepatitis B & C Client Records			✓		
CF 04 HIV/AIDS Client Records			✓		
CF 05 Syphilis Client Records			✓		
CF 06 Tuberculosis Client Records			✓		
CF 07 Client Logs	✓	✓	✓	✓	

Retention Schedule – Programs & Services Listed by OPHS

Chronic Diseases & Injuries CDI – page 56	Family Health FH – page 73	Infectious Diseases ID – Page 93	Environmental Health EH – Page 104	Emergency Preparedness EP – Page 116
CDI 01 General	FH 01 General	ID 01 General	EH 01 General	EP 01 General
CDI 02 Population Health Assessment	FH 02 Population Health Assessment	ID 02 Population Health Assessment	EH 02 Population Health Assessment	EP 02 Population Health Assessment
CDI 03 Surveillance	FH 03 Surveillance	ID 03 Surveillance	EH 03 Surveillance	EP 03 Surveillance
CDI 04 Research & Knowledge Exchange	FH 04 Research & Knowledge Exchange	ID 04 Research & Knowledge Exchange	EH 04 Research & Knowledge Exchange	EP 04 Research & Knowledge Exchange
CDI 05 Program Evaluation	FH 05 Program Evaluation	ID 05 Program Evaluation	EH 05 Health Statistics &	EP 05 Program Evaluation
Chronic Disease Prevention	**Reproductive Health**	**Infectious Diseases Prevention & Control**	**Food Safety**	EP 06 Emergency Preparedness
CDI 06 Healthy Eating	FH 06 Preconception Health		EH 06 Food Safety	
CDI 07 Healthy Weights	FH 07 Healthy Pregnancies	ID 06 Infectious Diseases Prevention & Control		EP 07 Emergency Contact Lists
	FH 08 Preparation for Parenting			
CDI 08 Comprehensive Tobacco Control	FH 09 Healthy Babies Healthy Children	ID 07 Infectious Disease Control Premise Inspections	**Safe Water** EH 07 Safe Water	
CDI 09 Physical Activity	**Child Health** FH 10 Positive Parenting	**Rabies Prevention & Control** ID 08 Rabies Prevention & Control	**Health Hazard Prevention & Management** EH 08 Health Hazard Prevention & Management	
CDI 10 Alcohol Use	FH 11 Breastfeeding			
	FH 12 Healthy Family Dynamics			
CDI 11 Exposure to Ultraviolet Radiation	FH 13 Healthy Eating, Healthy Weights, and Physical Activity	**Sexual Health, STI's & Blood Borne Infections incl. HIV** ID 09 Sexual Health Promotion	EH 09 Part 8/ Ontario Building Code Septic Systems	
CDI 12 Comprehensive Workplaces Wellness	FH 14 Healthy Growth & Development			
Prevention of Injury & Substance Misuse	FH 15 Oral Health	**Tuberculosis Prevention & Control** ID 10 Tuberculosis Prevention & Control		
CDI 13 Alcohol & Other Substances	FH 16 Healthy Babies Healthy Children			
CDI 14 Falls Across the Lifespan	FH 17 Early Child Health Identification and Intervention Programs	**Vaccine Preventable Diseases** ID 11 Vaccine Preventable Diseases		
CDI 15 Road & off Road Safety				
CDI 16 Other Areas of Public Health Importance for Prevention on Injuries	FH 18 Child & Youth Nurse Practitioner Led Programs			
	FH 19 Healthy Schools Program			

Draft Classification System / Retention Schedule – April 1, 2011

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AC – Accounting

– includes accounting activities common to MLHU

Activities/Record Series	Responsible Service/ Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AC 01 Accounting General Records regarding the financial administration of MLHU which cannot be classified elsewhere. Use only if no other heading is available.	Finance & Operations	C+1	-	C+1	Protected		
AC 02 Accounts Payable Records relating to payable accounts for goods and services. Includes: invoices, correspondence, packing slips, cheque requisitions, payment approvals for training and copies of financial transactions, expense statements and receipts submitted by employees. Accounting reports such as adjustment/batch listings, posting journal, cheque register, vendor invoices and void cheques. Excludes: travel arrangements see Travel Administration AD 13; Reimbursement of travel expenses from external agencies see Accounts Receivable AC 03.	Finance & Operations	C+2	5	C+7	VR, Protected		73, 74, 159, 169, 174, 192, 193, 194, 252

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AC 03 Accounts Receivable Records relating to funds owing to the MLHU. Includes: invoices, billing listings, correspondence, reimbursement of travel expenses from external agencies, accounts receivable.	Finance & Operations	C+2	5	C+7	Protected		73, 74, 159, 169, 174, 192, 193, 194, 252
AC 04 Audits and Auditing Audit information related to MLHU's financial responsibilities. Includes: internal and external audit reports.	Finance & Operations	C+2	5	C+7	AR, Protected		252
AC 05 Banking This record series reflects the banking activities within MLHU. Includes: pre-numbered cheques and reversals, bank statements from various accounts, bank reconciliations, banking supplies, cash receipt summaries, debit and credit memos, petty cash, safety deposit box and banking correspondence.	Finance & Operations	C+2	5	C+7	Protected		252

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AC 06 Budgeting Evidence of the budgeting process within MLHU. Includes: signed annual budgets, cost-shared and 100% funding, one-time funding grants, and correspondence. The process documentation includes: service submissions, financial analysis, briefing notes, planning process.	Finance & Operations	C+2	5	C+7	AR, Protected		
AC 07 Financial Statements This record series contains the internal financial statements that MLHU prepares as part of its monthly responsibility and filings. Includes: annual audited financial statements, monthly operating statements.	Finance & Operations	C+2	5	C+7	AR, Protected		73, 159, 174, 194, 252
AC 08 Financial Reporting This classification contains the internal/external financial reporting documentation that MLHU prepares as part of its annual fiscal responsibility and filings. Includes: financial and statistical analysis reports.	Finance & Operations	C+2	5	C+7	AR, VR, Protected		73, 159, 174, 194, 252

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AC 09 General Ledger Accounting This classification contains evidence of accounting entries in the general ledger. Includes: postings, journal and trial balances, printouts of general ledger accounts, supporting documentation and correspondence.	Finance & Operations	C+2	5	C+7	Protected		73, 159, 174, 194, 252
AC 10 Grant Funding This record series relates to Federal, Provincial and Foundation grant revenue to MLHU. Includes: applications, submissions, research proposals, reports, and acknowledgements.	Finance & Operations	C+2	5	C+7	Protected		73, 159, 174, 194, 252
AC 11 Insurance This record series reflects the various insurance requirements of MLHU including liability, errors and omissions and operating insurance. Includes: insurance policies, statistical reports, insurance claims, settlements, certificates of insurance and correspondence.	Finance & Operations	C+2	1	C+3	Protected	Re insurance claims: retain until claim settled & appeal period expired.	64, 65, 252

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AC 12 Inventory Asset Management This record series contains information related to the Inventory Asset Management system within MLHU for tracking and management of vehicle and equipment maintenance and warranty records, equipment lifecycles including replacements, receipts, leasing, disposal and donation. Includes: asset disposal forms, inventory lists, vehicle maintenance records.	Finance & Operations	S/O+1	2	S/O+3	VR, Protected	See IT 05 Support & Operations for tracking IT asset information	252

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AC 13 Payroll Administration This records series contains information related to the financial accounting and administration of employee salaries. Includes: employee salaries, Board honorariums, payroll deduction reports, payroll deductions, salary increments, mileage, non-routine employee attendance such as leaves of absence and supporting documentation, authorizations for payroll deductions, benefit payments. Excludes: pay equity and salary surveys see Compensation Management HR 04.	Finance & Operations	C+2	5	C+7	AR, PI, VR, Confidential	E = date (day or week) to which information relates	7, 8, 237, 242, 243, 248, 252
AC 14 Pension Records This record series reflects OMERS pension obligations due to MLHU staff. Includes: annual statements, interruption of service, optional enrollment and monthly remittances. Excludes: interruption of service, optional enrolment – see HR 08 Personnel Files.	Finance & Operations	C+2	97	C+99	PI Confidential		7, 8, 252, 253

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Activities/Record Series	Responsible Service/ Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AC 15 Purchasing This record series relates to the purchasing of goods, services, furniture and equipment. Includes: all competitive bid processes, which include quotes, tenders, proposals, expressions of interest; quotes, purchase orders, packing slips, receipts. Excludes: warranty information see Vendors and Suppliers AD 14.	Finance & Operations	C+2	5	C+7	VR, Protected		79, 252
AC 16 Taxation This record series relates to the taxes and taxation process within MLHU. Includes: required tax remittance and GST/HST reporting.	Finance & Operations	C+2	5	C+7	AR, Protected		1, 2, 3, 4, 5, 9, 10, 11, 12, 13, 66, 67, 68, 69, 70, 71, 72, 73, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177

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AD 01 Administrative General This record series contains administrative records which cannot be classified elsewhere. Use only if no other heading is available.	Originating Service or Program	C+1	-	C+1	Unrestricted		
AD 02 Appreciation & Complaints This record series reflects appreciation or complaints related to the Health Unit from clients, staff, or other agencies. Includes: incident report forms. Excludes: employee workplace incident/ accident reports see Occupational Health and Safety HR 06. Complaints related to delivery MLHU Programs e.g. Infectious Diseases Prevention and Control ID 06; Food Safety EH 06; Health Hazard Prevention and Management EH 08; etc.	Originating Service or Program	C+1	4	C+5	Protected	HRLR will retain original of employee related complaints when required by policy	

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AD 03 Committees, Meetings, Agencies, Groups and Task Forces This record series contains administrative and program information related to internal and external committees, meetings, agencies, groups and task forces. Includes: agendas, minutes, attachments, reports, terms of reference, briefing notes, correspondence, presentations and background information. Sub activity: -01 Internal -02 External Excludes: Board of Health and Board Standing Committees see CR 05; Memberships see AD 08; Joint Health and Safety Committee Minutes see HR 06, Union Management meetings see HR 05 Labour Relations.	Originating Service or Program	C+2	1	C+3	AR Protected	P = Directors Committee	78

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AD 04 Conferences This record series contains information related to invited presentations, panels or keynote addresses at conferences attended by MLHU staff or hosted by MLHU. Includes: abstract submissions, acceptance letters, poster and oral presentations, displays, conference programs, registrations. Excludes: attendance at conferences for staff development and training purposes see HR 11; Travel Administration see AD 13.	Originating Service or Program	C+3	-	C+3	AR, Protected		

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AD 05 Consultants and Contractors This record series contains information regarding the selection, appointment and monitoring of consultants and contractors. May include similar records regarding legal solicitors and engineering firms. <u>Includes:</u> correspondence, requests for information, letters of intent, proposals, resumes, bidder information sheets and other background documentation. <u>Excludes:</u> invoices see Accounts Payable AC 02; Quotations and tenders see Corporate Project Management see AD 11.	Finance & Operations Originating Service or Program (copies)	E+2 S/O	5 -	E+7 S/O	Protected	E= Termination of the proposal process and awarding of the contract.	

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AD 06 Court Filings This record series contains information related to Programs that have an enforcement component attached to them. These programs issue tickets that are a result of an investigation and may be contested in a court of law. This classification may also reflect someone suing MLHU. Includes: tickets, pictures, inspectors' reports lawyers' letters, summons, court orders, subpoenas and investigative/background information. Excludes: client records.	Originating Service or Programs	E+1	19	E+20	AR, PI, VR Restricted	E=Resolution of the court case	7, 8, 108, 197, 252, 291
AD 07 Mail and Courier Service Administration This record series reflects the administration of the internal and external mail service and courier service provided to MLHU. Includes: correspondence, tracking forms.	Finance & Operations	C+2	-	C+2	Protected		

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AD 08 Membership Administration This record series manages the information related to staff and corporate memberships in various societies and associations. Includes: application forms, renewal forms, correspondence. Excludes: payment and receipts for memberships see Accounts Payable AC 02.	Originating Service or Program	S/O	1	S/O+1	Unrestricted		
AD 09 Operational and Program Planning This record series contains information on MLHU's operational and program planning, including annual outcome reports. Includes: background/implementation information about plans and planning process, tools, forms, evaluation plans, assessment tracking forms, service/team activities, logic models, work plans, resources, and presentations. Excludes: strategic planning, see Board of Health Committee and Standing Committees of the Board CR 05.	OMOH and Originating Service or Program	S/O+1	4	S/O +5	VR, AR Protected		122, 123, 261

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AD 10 Policies, Procedures, Manuals and Guidelines Administration This record series contains agency, service and program policies, procedures, manuals, practice guidelines and other guidelines. Includes: policy manuals, procedural documents, best practice guidelines and directives related to both administrative and operational activities of MLHU.	Originating Service or Program	S/O+2	3	S/O+5	AR, VR, Protected	OMOH responsible for Administration Policy Manual	86, 136, 205, 222, 223
AD 11 Corporate Project Management This record series contains information related to administrative or corporate projects such as building and construction projects and IT projects. The project lead is responsible for maintaining all information related to these types of projects. Includes: project plans, schedules and reports, directives, change orders, project data, tenders, quotes and approvals.	Originating Service or Program	E+2	5	E + 7	PI, AR Protected	E= completion of the project	7, 8, 80, 81, 82, 83, 84, 87, 90, 92, 100, 252

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AD – Administrative

– includes administrative activities common to MLHU

Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AD 12 Records Management This record series reflects the activities associated with the application of systematic control of MLHU's recorded information from creation to ultimate disposal regardless of media type. Includes: records transfer listings, record destruction lists, transmittals and inventory holdings.	OMOH	P	-	P	AR, VR Protected		224, 225, 228, 229, 230, 254, 256, 259
AD 13 Travel Administration This record series reflects the activities involved in booking travel and accommodations for MLHU staff and Board Members to attend conferences, workshops and out of town meetings. Includes: travel itineraries, transportation, meals, and accommodations. Excludes: employee expenses see AC 02.	Originating Service or Program	C+2	-	C+2	Confidential		

Draft Classification System / Retention Schedule – April 1, 2011

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AD 14 Vendors and Suppliers This record series reflects information on the vendors and suppliers of goods and services used by MLHU as well as information about these goods and services. Includes: catalogues, price lists and warranty information. Excludes: purchasing of equipment see Purchasing AC 15.	Originating Service or Program	E+1	-	E+1	Unrestricted	E=End of the warranty period or disposal of equipment.	86, 101
AD 15 Visits and Tours This record series reflects the information relating to visits and tours to MLHU by local and foreign health care professionals, interested in public health in Ontario. Includes: itineraries, agendas, delegate lists, contact information, presentations.	Originating Service or Program	C+1	-	C+1	AR, Unrestricted		

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BU – Building Services

– includes building services activities within MLHU

Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
BU 01 Building General This record series contains building records which cannot be classified elsewhere. Use only if no other heading is available.	Finance & Operations	C+1	-	C+1	Unrestricted		
BU 02 Property Management This record series contains information related to the management of snow removal, janitorial services, automation systems (HVAC & Security) summer yard maintenance, pest control, fire equipment maintenance, generator maintenance, building structure, hazard identification and building drawings. Excludes: Facilities Construction and Renovations see Corporate Project Management AD 11; Contractors see Consultants and Contractors AD 05. For room bookings use Building General BU 01.	Finance & Operations	C+2	3	C+5	Protected		70, 89, 90, 122, 157, 158, 231, 232, 233, 251, 252, 263, 266, 289

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BU – Building Services

– includes building services activities within MLHU

Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
BU 03 Building Security This record series contains information related to the security of offices, buildings, and properties such as automated building security measures and security codes. Includes: the control of keys, fire alarms, smoke detectors, fire extinguishers, staff identification cards, building-on call list and after hour security requests and schedules. Excludes: computer security and access privileges see Security Management IT 04.	Finance & Operations	C+2	1	C+3	VR, Restricted		89, 91, 251, 252
BU 04 Building Systems and Equipment Testing This record series contains information related to conducting equipment testing as scheduled for all Building Services. Includes: fire equipment, elevator, lighting checks and generator tests.	Finance & Operations	E+5	-	E+5	Protected	E = date of last entry	99, 101, 102, 103, 104, 105, 106, 158, 251, 252, 263, 264, 265, 266

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BU – Building Services

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
BU 05 Parking This record series contains information relating to the maintenance and management of the parking system including issuing and recovering parking cards and tokens. Includes: listings for parking cards, stickers, parking map, parking enforcement, correspondence. Excludes: Consultants and Contractors see AD 05; Contracts, Agreements and Leases Management see CR 07.	Finance & Operations	S/O +1	1	S/O + 2	Protected		
BU 06 Equipment Leases This record series contains information related to equipment leases e.g. photocopiers, fax machines etc. See also CR 07	Finance & Operations	S/O + 2	-	S/O + 2			

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CM – Communications

– includes communication activities common to MLHU

Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CM 01 Communications General The program and service areas are responsible for developing communications strategies and tools in consultation with Communication staff. Communications works closely with all Service Areas to support the development and delivery of programs and services to staff and the public. This applies for all Communications activities/record series. This record series contains communications records that cannot be classified elsewhere. Use only if no other heading is available.	Originating Program or Service	C+1	-	C+1	Protected		

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CM 02 MLHU Website This record series contains information posted on the MLHU website and all supporting documentation. Includes: content/documents, web links, graphics and photos, website submissions, web metrics, web publishers/administrator and correspondence. Excludes: technical aspects of Control Panel see Infrastructure IT 03.	OMOH	S/O+2	-	S/O+2	AR, VR, Protected		252
CM 03 Annual Report This record series contains annual reports developed by MLHU. Includes: dissemination strategies and distribution lists.	OMOH	P	-	P	AR Unrestricted	C + 1 for records related to production and distribution	

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CM 04 Graphic Standards This record series contains information on use of the corporate identity including the MLHU corporate logo and slogans. Also includes other logos and slogans developed by MLHU programs and services. Includes: visual identity manuals, logos and slogans. Sub-activities: -01 Corporate -02 Programs/Services Excludes: logos and slogans from other agencies and institutions. See Copyrights and Trademarks Administration CR 09.	OMOH	P	-	P	AR Protected		

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CM 05 Media This record series reflects information issued by MLHU to print and electronic media. Includes: media advisories, news releases, interviews/statements, newspaper articles, public service announcements, paid advertisements, media kits, and all related submission/approval forms, activity tracking and reports.	OMOH	C+3	-	C+3	AR, VR, Protected	P = Newspaper Articles	
CM 06 Newsletters This record series contains corporate newsletters and program newsletters produced by MLHU for staff and/or the public. Includes: newsletters, submission/approval forms, dissemination strategies and related information. Sub-activities: -01 Corporate -02 Programs/Services	Originating Service or Program	C+3	2	C+5	AR Protected	P = Corporate Newsletters	

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CM 07 Promotional and Educational Materials This record series contains promotional materials developed for the public by MLHU, coalitions or community partnerships of which MLHU is a member, and where the MLHU corporate logo or slogan appears. Includes: audios, videos, posters, flyers, factsheets, brochures, booklets, handbooks, photographs and consent forms, billboards, bus advertisements, displays, games, calendars, guides, teaching kits, incentive items, and messages on the MLHU electronic sign.	Originating Service or Program OMOH when design firm contracted	C+3	2	C+5	AR Protected		

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CM 08 Translation Inventory and Related Documents This record series reflects the activity of translating MLHU documents into French or other languages. This includes a list of translators and the verification/editing process of the translation done by MLHU staff. Includes: list of agencies that provide translations, ministry approved translators, contact information, translation inventory and related documents. Excludes: final translated documents. These are filed in the same classification as the final original document.	Originating Service or Program	E+1	-	E+1	Unrestricted	E= verification and publication of the translation	

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CM 09. Health@mlhu.on.ca This record series includes emails addressed to Health@mlhu.on.ca and responses provided by Health Unit staff. Sub-activities: -01 Routine inquiries e.g. general information about Health Unit programs and services -02 Requests for health information/advice -03 Excludes: spam.	OMOH	01-E+1 02-E+2	- 23	E+1 E+25	Unrestricted PI, Protected Confidential	E= date response provided	

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CR – Corporate

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CR 01 Corporate General This record series contains corporate records which cannot be classified elsewhere. Use only if no other heading is available.	OMOH	C+1	-	C+1	Unrestricted		
CR 02 Accreditation This record series reflects the accreditation process within MLHU. It involves the documented evidence gathered to support accreditation standards. <u>Includes:</u> accreditation standards, preparations and documentation, application for assessment, questionnaires, surveys, presentations, training modules, internal/external communication, continuous quality improvement and background information.	OMOH	E+2	-	E+2	AR, Protected	E=Keep for 1 Accreditation Cycle P= survey results and awards	135, 151

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CR 03 Acts, Legislation and Regulations Administration This record series contains acts, legislation and regulations that impact on MLHU's mandate and may include background information and submissions.	Originating Service or Program	S/O+1	-	S/O+1	AR, Protected		
CR 04 Freedom Of Information And Protection Of Privacy This classification reflects the Freedom Of Information and Protection of Privacy and Personal Health Information Protection Act activities within MLHU including responses to information requests, review systems and file management to ensure that records are privacy compliant. Processes formal requests for information are in accordance with the legislation. <u>Includes:</u> formal requests and responses.	OMOH	E +2	3	E +5	PI Confidential	Privacy Application Period Where Individual Deceased: Event + 50 years (E = death of individual) Event + 100 years (E = record created)	7, 8, 224, 225, 226, 227, 228, 229, 230, 245, 246, 254, 255, 256, 257, 258, 259, 260

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CR 05 Board of Health Committee and Standing Committees of Board This classification contains information on Board of Health meetings and on Board of Health subcommittees. Includes: agendas, minutes of meetings, MOH reports, addendums, presentations, briefing notes, correspondence, orientation for board members, by laws, motions and resolutions, photos and corporate strategic plans. Excludes: all other committees see AD 03.	OMOH	P	-	P	AR, PI, VR, Confidential	In camera minutes and some briefing notes are restricted	75, 76, 77, 78, 190, 196, 197, 202, 207, 252, 291
CR 06 Board Membership This record series contains information regarding the appointment of Board members. Includes: resumes, applications and appointments.	OMOH	P	-	P	AR Confidential		

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CR 07 Contracts, Agreements and Leases Management This file series contains all original, signed contracts and agreements binding MLHU for services and products. See also BU 06 Equipment Leases Includes: partnerships, professional/formal, affiliations with academic institutions, building, leases, affiliation agreements, in-kind, independent contracting, maintenance agreements, facility agreements, software licensing and service contracts. Excludes: collective agreements see Labour Relations HR 05.	Finance & Operations	E + 2	5	E + 7	AR, VR, Protected	E=Termination of agreement, lease or contract	71, 252

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CR – Corporate

– includes corporate activities common to MLHU

Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CR 08 Corporate Documents Management This classification contains documents identifying MLHU as an entity under the law as a corporation without shared capital. Includes: articles of incorporation and corporation profile report.	Finance & Operations	P	-	P	AR, VR, Confidential		76, 190, 202
CR 09 Copyrights and Trademark Administration This record series reflects the activity of seeking copyright approvals for printed matter to be used by MLHU or for external agencies seeking approvals for MLHU copyrighted documents. This classification also includes trademark information. Includes: copyright requests, approvals, statements, license and invention disclosure form. Sub activity: -01 MLHU Requests to External Agencies for Copyright Approvals	Human Resources & Labour Relations	E+1	2	E+3	Protected	E=The date trademark registered	6, 21, 23, 24, 25, 26, 252

Draft Classification System / Retention Schedule – April 1, 2011

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
-02 Requests from External Agencies for MLHU Copyright Approvals -03 Trademarks Administration							
CR 10 Library Services This record series reflects library services and activities provided to staff, students on placement, and volunteers. Includes: literature search strategies, interlibrary loans, resources circulation, reference service, classification and cataloguing, presentations, acquisitions and journals lists, reporting and statistics related to library services.	HR & LR	S/O	-	S/O	AR, Unrestricted		21, 22, 23

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CR – Corporate

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CR 11 Development Projects This record series contains special projects and activities related to public health development such as public health renewal, determinants of health and health equities, professional and public health practice. Includes: plans, correspondence, background documentation, reports and publications, presentations. Excludes: healthy public policy see specific initiatives within Programs and Services.	Originating Service or Program	C+2	5	C+7*	PI, AR, VR, Confidential	P = Reports, to be determined on a case by case basis *Total retention for funded projects is based on requirements of funding agency.	

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HR – Human Resources

– includes human resource activities common to MLHU

Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 01 Human Resources General Records regarding human resources which cannot be classified elsewhere. Use only if no other heading is available.	Human Resources & Labour Relations (HRLR)	C+1	-	C+1	Protected		
HR 02 Attendance Management Records regarding routine attendance, vacations, hours of work and leaves. Includes: vacation schedules, compressed work week requests and schedules, attendance management. Excludes: non-routine leave see Payroll Administration AC 13.	HRLR	E+3	-	E+3	PI Confidential	E=day leave expired.	7, 8, 234, 235, 237, 238, 239, 242, 244

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HR – Human Resources

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 03 Benefits Administration This record series reflects the benefits offered to MLHU staff as part of their employment contract as well as to review the development of a benefits philosophy and plan to align benefits package and assess benefits quote in order to capitalize on quality and cost of benefits package for all MLHU employees. Includes: rates, quotes and correspondence. Excludes: benefit applications, change forms – see Personnel Files HR 08	HRLR	C+2	5	C+7	PI Confidential		7, 8, 194, 252

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HR – Human Resources

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 04 Compensation Management This record series contains information on the compensation of positions within MLHU in order to ensure that salaries are compliant with pay and internal equity and job market. Includes: documents for pay equity, job evaluation including questionnaires, advice of rating, ratings and reconsideration documentation and salary surveys. Excludes: Payroll Administration see AC 13.	HRLR	S/O+3	3	S/O+6	PI Confidential	P=final documents Retention periods adjusted from Directors Committee review	7, 8, 234, 243, 248, 252
HR 05 Labour Relations This record series contains information related to MLHU labour relations. Includes: seniority lists, bargaining notes, collective agreements, grievances, and Labour Board material, Union Management minutes. Excludes: all other contracts and leases see CR 07; see Payroll Administration AC13.	HRLR	S/O+3	3	S/O+6	AR, VR, Confidential		234, 252

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HR – Human Resources

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 06 Occupational Health & Safety This record series applies to the occupational health and safety of staff and provides reports as legislated. Includes: hazard, accident and incident reports[1], Ministry of Labour orders, information on health and safety programs for staff, CPR and first aid courses, ergonomic assessments[1], fire safety orientation, fire drills, workplace inspection, Joint Health and Safety Committee Minutes.	OMOH	S/O+2	8	S/O+10	PI, VR, Confidential	2 most recent records/ reports must be kept on file [1] retained by HRLR when related to individual employee	7, 8, 85, 88, 91, 221, 222, 223, 234, 247, 249, 250, 251, 252, 261, 262, 267, 280, 283
HR 07 Organizational Structure and Functions This record series contains information on the organizational structure of MLHU including reporting relationships and position hierarchy. Includes: organizational charts, position descriptions[1], succession planning, reorganization analysis and plans. Excludes: core competencies see Orientation & Staff Development/Training HR 11.	Originating Service or Program [1] HRLR	S/O+1	-	S/O+1	AR Unrestricted		

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HR – Human Resources

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 08 Personnel Files This record series contains information documenting the work history of part-time, full-time, and paid student employees. Includes: resumes, offer of employment, recommendations for hire, acceptance letters, pre-employment testing, payroll documents, immunization records, Workplace Safety Insurance Board (WSIB) information, benefit and pension documents , application for internal job postings, commendations, certification requirements, credentials required for position, e.g. CPR and First Aid certificates, professional memberships/certification, performance management forms, recognition and disciplinary letters,accommodation and return to work plans, exit interview. Excludes: volunteers see Volunteer Screening and Orientation HR 13; Ontario Education Services Corporation criminal reference checks use HR 01.	HRLR	E+3	4	E+7	PI, VR, Confidential	E=Employee Termination Exception: Disciplinary letters should be purged according to applicable collective agreement / contract	7, 8, 234, 236, 237, 238, 240, 241, 242, 244, 252, 253

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 09 Recruitment Administration of creating, scheduling and advertising employment opportunities and the recruitment of staff. Includes: internal job postings and advertisements, interview questions. Excludes: offer letters, recommendation of hire, pre-employment testing see Personnel Files HR 08.	HRLR	C+2	3	C+5	PI Protected	Interview questions may be retained longer. Resumes, reference checks and correspondence from unsuccessful applicants confidentially destroyed after 6 months As noted on the MLHU website, unsolicited resumes are not retained. They are shredded on receipt.	7, 8, 234

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 10 Staff Recognition This record series contains information related to staff or employee service milestones and retirements. Includes: staff & Volunteer recognition awards lists, Staff Day.	OMOH 1 HRLR	E+2	-	E+2	AR, Unrestricted	E=date of service milestone/ retirement	234
HR 11 Orientation and Staff Development/ Training This record series contains information relating to volunteer and staff orientation and professional development. Includes: corporate and Service Area orientation presentations and training materials, corporate/Service Area staff development plans, needs assessments, corporate and Service Area staff development activities such as in-services, conferences, workshops, seminars, knowledge exchange symposiums, registrations, agendas, course descriptions, forms and approvals, activity tracking, statistics, reports, and correspondence.	Originating Service or Program	S/O+2	3	S/O+5	AR, VR, Unrestricted		71, 144, 234, 252

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Sub-activities: -01 Staff Orientation -02 Staff Development/Training Excludes: orientation and training of students on placement see Student Placement Program HR 14; Orientation and Training of Volunteers see HR 13; Orientation for Board members see CR 05; Travel Administration see AD 13.							
HR 12 Volunteer Program This record series contains information relating to the administration, coaching, mentoring and efficient delivery of the Volunteer Program. Includes: Volunteer Satisfaction Surveys, volunteer requests and role descriptions. Excludes: professional development see HR 11, Posters, Handbooks see CM 07; Newsletter see CM 06; Volunteer Resources Manual see AD 10; Volunteer personnel files see HR 08.	HRLR	C+2	-	C+2	AR, VR, Confidential		234, 252

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HR – Human Resources

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 13 Volunteer Screening and Orientation This record series relates to information on the screening and orientation of volunteers. Includes: volunteer applications, interview questions, verifying references, immunization records, orientation documents and scheduling. Excludes: Criminal Reference Checks use HR 01; Volunteer training see HR 11.	HRLR	E+3	-	E+3	PI, AR Confidential	E = last day on which work performed under agreement	234, 237, 238, 242, 252

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HR – Human Resources

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 14 Student Placement Program This record series reflects the activities surrounding the placement of post secondary students within MLHU and preceptorship activities. Includes: student placement information, correspondence, feedback/communication to students, resources, reporting and activity tracking, forms used to evaluate the student program and aggregate evaluation reports, student orientation, staff preceptor training and appreciation events, reports and publications, presentations. Excludes: affiliation agreements see CR 07.	HRLR	C+2	3	C+5	PI, AR Confidential	Evaluations of student performance completed by MLHU staff are the property of the academic institution. Feedback compiled by staff to assist in completing the evaluations and copies of correspondence sent to students are retained for one year and then shredded.	71, 72

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HR – Human Resources

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
HR 15 Education Services – Post Secondary Institutions This record series reflects the academic partnerships and teaching/educational activities provided by staff, who maintain a faculty or joint appointment with an academic institution. Includes: teaching, course facilitation, curriculum development or review, thesis supervision, guest lectures, seminars, workshops and presentations. Excludes: student placements see HR 14; Affiliation agreements see CR 07.	Originating Program or Service	S/O+2	3	S/O+5	AR Protected		252

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IT – Information Technology

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
IT 01 Information Technology General This record series contains Information Technology records which cannot be classified elsewhere. Use only if no other heading is available.	Information Technology	C+1	-	C+1	Protected		
IT 02 Applications This record series contains records related to computer application including: ▪ Business Analysis, Project Management, application selection/implementation. ▪ Business process improvement. ▪ Data analysis. ▪ Core I.T. applications including e-mail, core desktop applications, web/intranet services, database services, telephone/voice applications, etc. ▪ Application standards. <u>Includes:</u> software (itself), software licenses/agreements, license keys, application and system designs, maintenance specifications, implementation plans, and	Information Technology	S/O+2	-	S/O+2	VR, Protected		252

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IT – Information Technology

– includes information technology activities common to MLHU

Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
quality control. Excludes: contracts, agreements and leases see CR 07, Asset Information see Support and Operations IT 05.							
IT 03 Infrastructure This record series contains information related to the Information Technology "infrastructure" including: ▪ Desktop/laptop/mobile devices & standards. ▪ Servers, storage, tape backup and uninterruptable power supply. ▪ Wired and wireless network devices and cable plant. ▪ Inter-site connectivity. ▪ Internet access. ▪ Telephony devices—handsets, servers, switches, etc. Includes: documentation related to infrastructure configuration, deployment, processes and standards. Excludes: IT asset information, see Support &	Information Technology	S/O +2	-	S/O+2	Protected		

Draft Classification System / Retention Schedule – April 1, 2011

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Operations IT 05; Purchase/acquisition Information see Purchasing AC 15.							
IT 04 Security Management This record series addresses the following areas related to I.T. security: ▪ Standards development and documentation. ▪ Data security technologies and approaches including encryption. ▪ Investigation and audit. ▪ Firewalls and remote access. Includes: documentation of security standards and approaches of network applications systems, computers/servers, firewalls, telephones and blackberries, documentation of passwords, encryption keys etc. Excludes: Freedom of Information Requests see CR 04; Building security codes see Building Security BU 03.	Information Technology	S/O+2	-	S/O+2	VR, Confidential		252

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Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
IT 05 Support & Operations This records series contains information related to the support and operation of the I.T. environment including: ▪ Helpdesk—client support. ▪ Client Training. ▪ Account i.e. network ID's management. ▪ Infrastructure monitoring, trending/forecasting. ▪ Device build and configuration. ▪ Device/application refresh and deployment. ▪ Patch deployment. ▪ E-mail support and troubleshooting. ▪ Asset tracking/management. ▪ Preventative maintenance. ▪ Data backup/restore. <u>Includes:</u> training documentation, schedules and evaluation, support requests/trouble tickets and resolution information, logs and supporting operational data, asset information (in database,) backups (e.g. configuration backups of network switches, tape/system backups)	Information Technology	S/O+2	-	S/O+2	Protected		252

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

CF – Client Files

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CF 01 Community as Client This record series contains records documenting provision of services where a community or group is the client e.g. schools, workplaces, or community groups. Includes: "group" record, e.g. Workplace Program Consultation Form, Elementary and Secondary School records that document group assessments, planning, interventions and outcomes. Excludes: charts where an individual is the client see Client Records CF 02-06; logs of one on one client contact where contact is not expected to recur, see Client Logs CR 07.	Originating Service or Program	C+2	13	C+15	PI, VR, Confidential		7, 8, 14, 15, 16, 17, 18, 51, 52, 53, 178, 179, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 204, 216, 218, 219, 220, 286, 287, 288, 291
CF 02 Client Records This record series contains client records for programs where comprehensive one on one contact, which may be repeated, is expected to occur e.g. Healthy Babies Healthy Children; Smart Start for Babies; Preschool Speech and Language; Infant Hearing and Blind Low Vision Intervention Programs; Oral Health Preventive	Originating Service or Program	E+2*	23*	E+25*	PI, VR, Confidential	E= date of client's last contact OR E= date exemption form signed * For Vaccine	7, 8, 14, 15, 16, 17, 18, 19, 20, 51, 52, 53, 54, 55, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 198, 200, 201, 203, 204, 211, 212, 213, 214, 215, 216, 217, 218, 219,

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

CF – Client Files

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
and Treatment Programs; sexually transmitted infections; enteric diseases i.e. reportable diseases, including public health management of cases and outbreaks; vaccine preventable diseases; and prevention and control of rabies. Includes: assessments, progress notes, referrals, consents, correspondence, practitioner reports, inspector notebooks, listings of common abbreviations; immunization records including consent forms, notarized exemption forms, immunization clinic staff sign in sheets, suspension orders (filed by school); Travel Questionnaires completed prior to immunization; Oral Health Client Records (i.e. School Files; CINOT* client and Screening Records; Healthy Smiles Ontario (HSO) Client Records; Preventive Care clinical dental records; CINOT, HSO, and Middlesex Ontario Works eligibility records; rabies case files and investigations. * Children In Need of Treatment Excludes: CR 01 Community as Client; CF 03 Hepatitis B and C client records; CF 04 HIV/AIDS client records; CF 05 Syphilis client						Preventable Diseases Program refers to paper records. IRIS records kept permanently. To be revisited when Panorama operational. P= Inspector Notebooks	220

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

CF – Client Files

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
records; CF 06 Tuberculosis client records; CF 07 Client Logs.							
CF 03 Hepatitis B & C Client Records Records relating to persons with Hepatitis B & C. Includes: case notification, lab reports, progress notes, consent for release of information, medical correspondence, etc.	OHCDSHS	E+4	P	P	PI, VR, Confidential	E=Date of client's last contact	7, 8, 14, 15, 16, 17, 18, 51, 52, 53, 178, 179, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 204, 216,218, 219, 220, 286, 287, 288,291
CF 04 HIV/AIDS Client Records Records relating to persons with Human Immunodeficiency Syndrome (AIDS). Includes: case notification, lab reports, progress notes, consent for release of information, medical correspondence, etc.	OHCDSHS	E+4	P	P	PI, VR, Confidential	E=Date of client's last contact	7, 8, 14, 15, 16, 17, 18, 51, 52, 53, 178, 179, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 204, 216,218, 219, 220, 286, 287, 288,291
CF 05 Syphilis Client Records Records relating to persons with Syphilis. Includes: case notification, lab reports, progress notes, consent for release of information, medical correspondence, etc.	OHCDSHS	E+5	P	P	PI, VR Confidential	E=Date of client's last contact	7, 8, 14, 15, 16, 17, 18, 51, 52, 53, 178, 179, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 204, 216,218, 219, 220, 286, 287, 288,291

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

CF – Client Files

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CF 06 Tuberculosis Client Records Records relating to persons with tuberculosis. Includes: consent forms, lab results, progress notes, prescriptions, client histories, assessment forms, referrals, background information, etc.	OHCDSHS	E+3	P	P	PI, VR, Confidential	E=Date of client's last contact	7, 8, 20, 51, 53, 55, 178, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 198, 201, 204, 211, 212, 213, 216, 217, 218, 219, 220, 291
CF 07 Client Logs This record series contains information related to one on one interactions with clients that are not expected to be recurring. This record series reflects the telephone triage done by staff when called by the public regarding health issues, and logs kept by nurses, dieticians, and other health unit staff interacting one on one with individual clients outside of a recurring structured or clinical program. Includes: clinic log sheets, daily intake logs, after hour logs, phone logs re immunization suspensions, and elementary and secondary school records that document assessments and interventions with individual students. Excludes: Community as Client Documentation	EHCDPS FHS OHCDSHS	E+2	23	E + 25*	PI, VR, Confidential	E=date of client contact	7, 8, 218

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CF – Client Files

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
see CF 01 and charting that occurs as part of a clinic or as a result of an ongoing relationship with a client see CF 02-06.							

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

CDI – Chronic Diseases & Injuries

– includes records of programs and services to reduce the burden of preventable chronic diseases of public health importance i.e. cardiovascular diseases, cancer, respiratory diseases and type 2 diabetes (OPHS, 2008, p.18).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CDI 01 Chronic Diseases & Injuries General This record series contains Chronic Diseases & Injuries records which cannot be classified elsewhere. Use only if no other heading is available.	EHCDPS	C+1	2	C+3	Protected		
CDI 02 Population Health Assessment This series includes information related to measuring, monitoring and reporting the status of a population's health related to health behaviours, risks and trends associated with chronic diseases and injuries. Includes: correspondence, health statistics, data access, collection and management, data sets and analysis, technical notes, graphs, tables, maps, socio-demographic reports and health status reports, factsheets, reporting and dissemination strategies and related information. Excludes: contact tracing and program	EHCDPS	C+2	5	C+7	PI, AR, VR, Confidential	P= Demographic & Health Status Reports Retention of Fact Sheets determined on a case by case basis	

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
surveillance conducted by program staff; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
CDI 03 Surveillance This series contains information related to epidemiological analysis of surveillance data including monitoring trends over time, emerging trends and priority populations related to chronic diseases and injuries. <u>Includes:</u> correspondence, assessment and surveillance data, analysis, technical notes, graphs, tables, maps, socio-demographic and health status reports, fact sheets, dissemination strategies, activity tracking, literature and	EHCDPS	C+2	5	C+7	PI, AR, VR, Confidential	P= Demographic & Health Status Reports Retention of Fact Sheets to be determined on a case by case basis	

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
resource materials related to chronic diseases and injuries. Excludes: contact tracing and surveillance conducted by program staff; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
CDI 04 Research & Knowledge Exchange This series includes records related to identifying research questions, networking with community researchers, academic partners and others to support applied public health research and knowledge exchange and research undertaken by MLHU or in partnership with others related to chronic diseases and injuries. Includes: correspondence, ethics and internal	EHCDPS	C+2	5	C+7*	PI, AR, VR, Confidential	P= reports to be determined on a case by case basis * total retention for funded projects is based on the requirements of the funding agency	7, 8, 258

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
reviews, credentials of external investigators, project plans, data collection tools, findings, resources developed, reports, dissemination strategies, annual summaries of research undertaken. Excludes: presentations at conferences see AD 04; for staff development related to research and knowledge exchange see HR 11; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for Orientation & Staff Development / Training see HR 11.							
CDI 05 Program Evaluation This series contains records related to program evaluations, including needs assessments related to chronic diseases and injuries. Includes: correspondence. evaluation project plans, data collection tools, evaluation data, literature searches and references, findings,	EHCDPS	C+2	5	C+7*	PI, AR, VR, Confidential	P = Reports to be determined on a case by case basis *Total retention for funded research projects is based on requirements of funding	7, 8, 258

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
reports, dissemination strategies. Excludes: Grant Funding see AC 10; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration ; for conference presentations see AD 04; for staff development / training related to program evaluation including needs assessment see HR 11.						agency.	
Chronic Disease Prevention							
CDI 06 Healthy Eating See also FH 13 This series contains information related to health promotion and policy development initiatives focusing on healthy eating. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination	Originating Service or Program	C+1	5	C+6	PI, AR Protected	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179, 218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to healthy eating. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
CDI 07 Healthy Weights See also FH 13 This series contains information related to health promotion and policy development initiatives focusing on healthy weights. Includes: correspondence, campaigns, training and curriculum resources, registration forms,	Originating Service or Program	C+1	5	C+6	PI, AR Protected	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179, 218

Draft Classification System / Retention Schedule – April 1, 2011

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
consultations, Health Unit published resources, dissemination strategies, advocacy for healthy public policies, activity tracking, literature resource materials, and associated work plans related to healthy weights. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
CDI 08 Comprehensive Tobacco Control This series contains information related to health promotion and policy development initiatives focusing on tobacco control and health protection activities related to the implementation and enforcement of the Smoke-	EHCDPS	C+2	4	C+6	AR, PI, VR, Confidential	P= Inspector Notebooks * *Published works are not records. A copy of in-house reports is to be forwarded to the*	7, 8, 231, 232, 233, 289

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Free Ontario Act Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to comprehensive tobacco control. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 06 Court Filings; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.						*Health Unit Library*	

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CDI 09 Physical Activity See also FH 13 This series contains information related to health promotion and policy development initiatives focusing on physical activity. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to physical activity. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.	Originating Service or Program	C+1	5	C+6	AR, Protected, PI	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CDI 10 Alcohol Use See also CDI 12 This series contains information related to health promotion and policy development initiatives focusing on alcohol use. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to alcohol use. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.	Originating Service or Program	C+1	5	C+6	AR, Protected, PI	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
CDI 11 Exposure to Ultraviolet Radiation This series contains information related to health promotion and policy development initiatives focusing on exposure to ultraviolet radiation. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to exposure to ultraviolet radiation. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client	Originating Service or Program	C+1	5	C+6	AR. Protected, PI	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 126,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
records see CF 01-07.							
CDI 12 Workplace Program This series includes information related to workplace wellness programs delivered by Health Unit staff to employers and employees. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to preconception health. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff	Originating Service or Program	C+1	5	C+6	AR, PI Protected	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 126, 179, 218, 289

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Development / Training see HR 11; for client records see CF 01, 02 07.							
Prevention of Injury & Substance Misuse							
CDI 13 Alcohol & Other Substances See also CDI 10 This series contains information related to health promotion and policy development initiatives and health protection activities focusing on alcohol and other substances. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to alcohol and other substances. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09	Originating Service or Program	C+1	5	C+6	AR, PI, Protected	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
CDI 14 Falls Across the Lifespan This series contains information related to health promotion and policy development initiatives and health protection activities focusing on falls across the lifespan. <u>Includes:</u> correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to falls across the lifespan.	Originating Service or Program	C + 1	5	C + 6	AR, PI, Protected	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Excludes: AC 10 grant funded research proposals; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 04 conference presentations; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
CDI 15 Road and Off-Road Safety This series contains information related to health promotion and policy development initiatives and health protection activities focusing on road and off-road safety. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination	Originating Service or Program	C+1	5	C+6	AR, Protected, PI	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to road and off-road safety. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
CDI 16 Other Ares of Public Health Importance This series contains information related to other areas of Public Health importance for the prevention of injuries. Includes: correspondence, campaigns, training and curriculum resources, including	Originating Service or Program	C+1	5	C+6	AR, Protected, PI	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to other areas of Public Health importance for the prevention of injuries. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

FH – Family Health

– includes records of programs and services to enable individuals and families to achieve optimal preconception health, experience a healthy pregnancy, have the healthiest newborn(s) possible and be prepared for parenthood (OPHS, 2008, p. 25).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
FH 01 Family Health General This record series contains Family Health records which cannot be classified elsewhere. Use only if no other heading is available.	FHS	C+1	2	C+3	Protected		
FH 02 Population Health Assessment This series includes information related to measuring, monitoring and reporting the status of a population's health related to health behaviours, risks and trends associated with family health. Includes: correspondence, health statistics, data access, collection and management, data sets and analysis, technical notes, graphs, tables, maps, socio-demographic reports and health status reports, factsheets, reporting and dissemination strategies and related information. Excludes: contact tracing and program surveillance conducted by program staff; AD 03 Committees, Meetings, Agencies, Groups &	FHS	C+2	5	C+7	PI, AR, VR, Confidential	P=Demographic & Health Status Reports Retention of Fact Sheets determined on a case by case basis	

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

FH – Family Health

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
FH 03 Surveillance This series contains information related to epidemiological analysis of surveillance data including monitoring trends over time, emerging trends and priority populations related to family health. <u>Includes:</u> correspondence, assessment and surveillance data, analysis, technical notes, graphs, tables, maps, socio-demographic and health status reports, fact sheets, dissemination strategies, activity tracking, literature and resource materials and correspondence related to family health.	FHS	C+2	5	C+7	PI, AR, VR, Confidential	P=Demographic & Health Status Reports Retention of Fact Sheets to be determined on a case by case basis	

Draft Classification System / Retention Schedule – April 1, 2011

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Excludes: contact tracing and surveillance conducted by program staff; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
FH 04 Research & Knowledge Exchange This series includes records related to identifying research questions, networking with community researchers, academic partners and others to support applied public health research and knowledge exchange and research undertaken by MLHU or in partnership with others related to family health. Includes: correspondence, ethics and internal reviews, credentials of external investigators, project plans, data collection tools, findings, resources developed, reports, dissemination	FHS	C+2	5	C+7*	PI, AR, VR, Confidential	P= reports to be determined on a case by case basis * total retention for funded projects is based on the requirements of the funding agency	7, 8, 258

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
strategies, annual summaries of research undertaken. Excludes: presentations at conferences see AD 04; for staff development related to research and knowledge exchange see HR 11; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for Orientation & Staff Development / Training see HR 11.							
FH 05 Program Evaluation This series contains records related to program evaluations, including needs assessments related to family health. Includes: correspondence. evaluation project plans, data collection tools, evaluation data, literature searches and references, findings, reports, dissemination strategies, Excludes: Grant Funding see AC 10; AD 03 Committees, Meetings, Agencies, Groups &	FHS	C+2	5	C+7*	PI, AR, VR, Confidential	P = Reports to be determined on a case by case basis *Total retention for funded research projects is based on requirements of funding agency.	7, 8, 258

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for conference presentations see AD 04; for staff development / training related to program evaluation including needs assessment see HR 11.							
Reproductive Health							
FH 06 Preconception Health This series contains information related to health promotion and policy development initiatives focusing on preconception health. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to preconception health. Excludes: AD 03 Committees, Meetings,	Originating Service or Program	C+1	5	C+6	AR, PI Protected	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179, 218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
FH 07 Healthy Pregnancies This series contains information related to health promotion and policy development initiatives focusing on healthy pregnancies. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to healthy pregnancies.	Originating Service or Program	C+1	5	C+6	AR, Protected, PI	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
FH 08 Preparation for Parenting This series contains information related to health promotion and policy development initiatives focusing on preparation for parenting. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to	Originating Service or Program	C+1	5	C+6	AR, Protected, PI	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
preparation for parenting. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
FH 09 Healthy Babies Healthy Children See also FH 16 This series includes non- client records from the prenatal component of the Healthy Babies Healthy Children Program. Includes: correspondence, ministry reports, activity tracking, literature and resource materials and associated work plans related to prenatal components of Healthy Babies Healthy	FHS	C+1	5	C+6	AR, Protected, PI		7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Children. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
Child Health							
FH 10 Positive Parenting This series contains information related to health promotion and policy development initiatives focusing on positive parenting. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies,	FHS	C+1	5	C+6	AR, Protected, PI	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
activity tracking, literature, resource materials and associated work plans related to positive parenting. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
FH 11 Breastfeeding This series contains information related to health promotion and policy development initiatives focusing on breastfeeding. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination	FHS	C+1	5	C+6	AR, Protected, PI	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to breastfeeding. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
FH 12 Healthy Family Dynamics This series contains information related to health promotion and policy development initiatives focusing on healthy family dynamics. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations,	FHS	C+2	5	C+6	AR, Protected, PI	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
*Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to healthy family dynamics. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
FH 13 Healthy Eating, Healthy Weights, and Physical Activity See also CDI 06, CDI 07 and CDI 09 This series contains information related to health promotion and policy development initiatives focusing on healthy eating, healthy weights and	Originating Service or Program	C+1	C+5	C+6	AR, Protected, PI	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179, 218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
physical activity. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to healthy eating, healthy weights and physical activity. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
FH 14 Growth & Development This series contains information related to health promotion and policy development initiatives focusing on growth and development. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to growth and development. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.	FHS	C+1	5	C+6	AR, Protected, PI	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
FH 15 Oral Health This series contains information related to health promotion and policy development initiatives focusing on oral health and health protection activities related to monitoring of community water fluoride levels. Includes: fluoride reports/monitoring, correspondence, campaigns, training and curriculum resources, registration forms, consultations, Health Unit published reports, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans focusing on oral health. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff	OHCDSHS	C+1	5	C+6	AR, Protected PI		Re Fluoride-Section 13 of Ontario Regulations (at least 2 years) 54, 180, 181

Draft Classification System / Retention Schedule – April 1, 2011

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Development / Training see HR 11; for client records see CF 01, 02, and 07.							
FH 16 Healthy Babies Healthy Children See also FH 09 This series includes non-client records for the 0-6 year components of the Healthy Babies Healthy Children Program. Includes: correspondence, ministry reports, activity tracking, literature and resource materials and associated work plans related to Healthy Babies Healthy Children (0-6 years). Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client	FHS	C+1	5	C+6	AR, Protected, PI		7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
records see CF 01-07.							
FH 17 Early Child Health Identification and Intervention Programs This series includes non-client records for Smart Start for Babies, Preschool Speech and Language, Infant Hearing and Blind Low Vision programs and other programs that may be developed with a similar focus. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to early child health identification and intervention programs. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines	FHS	C+1	5	C+6	AR, Protected, PI	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
FH 18 Child & Youth Nurse Practitioner Led Programs This series includes non-client records of programs and initiatives focusing on children and youth that are led by a Nurse Practitioner. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to Child & Youth Nurse Practitioner led program. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09	FHS	C+1	5	C+6	AR, Protected, PI	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179,218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
FH 19 Healthy Schools Program This series includes non-client records related to programs and services in elementary and secondary schools. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to healthy schools program. Excludes: AD 03 Committees, Meetings,	Originating Service or Program	C+1	5	C+6	AR, PI Protected	* *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 179, 218

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

ID – Infectious Diseases

– includes records of programs and services to reduce the burden of infectious diseases of public health importance (OPHS, 2008, p. 30).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
ID 01 Infectious Diseases General This record series contains Infectious Diseases records which cannot be classified elsewhere. Use only if no other heading is available.	EHCDPS OHCDSHS	C+1	2	C+3	Protected		
ID 02 Population Health Assessment This series includes information related to measuring, monitoring and reporting the status of a population's health related to health behaviours, risks and trends associated with infectious diseases. Includes: correspondence, health statistics, data access, collection and management, data sets and analysis, technical notes, graphs, tables, maps, socio-demographic reports and health status reports, factsheets, reporting and dissemination strategies and related information. Excludes: contact tracing and program surveillance conducted by program staff; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see	EHCDPS OHCDSHS	C+2	5	C+7	PI, AR, VR, Confidential	P= Demographic & Health Status Reports Retention of Fact Sheets determined on a case by case basis	

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
ID 03 Surveillance This series contains information related to epidemiological analysis of surveillance data including monitoring trends over time, emerging trends and priority populations related to infectious diseases. <u>Includes:</u> correspondence, assessment and surveillance data, analysis, technical notes, graphs, tables, maps, socio-demographic and health status reports, fact sheets, dissemination strategies, activity tracking, literature and resource materials related to infectious diseases. <u>Excludes:</u> contact tracing and surveillance	EHCDPS OHCDSHS	C+2	5	C+7	PI, AR, VR, Confidential	P= Demographic & Health Status Reports Retention of Fact Sheets to be determined on a case by case basis	

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
conducted by program staff; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
ID 04 Research & Knowledge Exchange This series includes records related to identifying research questions, networking with community researchers, academic partners and others to support applied public health research and knowledge exchange and research undertaken by MLHU or in partnership with others related to infectious diseases. Includes: correspondence, ethics and internal reviews, credentials of external investigators, project plans, data collection tools, findings, resources developed, reports, dissemination strategies, annual summaries of research	EHCDPS OHCDSHS	C+2	5	C+7*	PI, AR, VR, Confidential	P= reports to be determined on a case by case basis * total retention for funded projects is based on the requirements of the funding agency	7, 8., 258

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
undertaken. Excludes: presentations at conferences see AD 04; for staff development related to research and knowledge exchange see HR 11; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for Orientation & Staff Development / Training see HR 11.							
ID 05 Program Evaluation This series contains records related to program evaluations, including needs assessments related to infectious diseases. Includes: correspondence. evaluation project plans, data collection tools, evaluation data, literature searches and references, findings, reports, dissemination strategies. Excludes: Grant Funding see AC 10; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program	EHCDPS OHCDSHS	C+2	5	C+7*	PI, AR, VR, Confidential	P = Reports to be determined on a case by case basis *Total retention for funded research projects is based on requirements of funding agency.	7, 8, 258

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for conference presentations see AD 04; for staff development / training related to program evaluation including needs assessment see HR 11.							
Infectious Diseases Prevention & Control							
ID 06 Infectious Diseases Prevention and Control This record series contains information related to health promotion and policy development initiatives and disease prevention and health protection activities related to infectious diseases prevention and control. <u>Includes:</u> correspondence, campaigns, training and curriculum resources, registration forms, consultations, Health Unit published resources*, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to infectious disease prevention and	EHCDPS OHCDSHS	C +1	5	C+6	PI, AR, Protected	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	7, 8, 14, 15, 16, 18, 191, 291

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
control. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 06 Court Filings; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01, 02, and 07.							
ID 07 Infectious Disease Control Premise Inspections This series contains information related to premise inspections conducted by the Infectious Disease Control Team e.g. long term care facilities, retirement homes, day care centers, hospitals, detention centres, personal service settings, funeral homes. Includes: all records related to inspection of long term care facilities, retirement homes, day care	OHCDSHS	E* + 2	23*	E+ 25	PI, VR, Confidential	E= date of inspection	7, 8, 14, 15, 16, 18, 191, 291

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
centers, hospitals, detention centres, personal service settings, funeral homes, including cold chain inspections. Excludes: for outbreaks see CF 02 Client Records; food premise inspections done by EHCDPS – see EH 06 Food Safety.							
Rabies Prevention & Control							
ID 08 Rabies Prevention and Control This record series contains information related to health promotion and policy development initiatives and disease prevention and health protection activities related to rabies prevention and control. Includes: post exposure statistics, vaccine stock and distribution inventory, rabies contingency plan, correspondence, campaigns, training and curriculum resources, registration forms, consultations, Health Unit published reports, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials related to rabies prevention	EHCDPS	C+1	5	C+6	PI, AR, VR, Protected		7, 8, 14, 15, 16, 17, 18, 51, 53, 178, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 200, 201, 204, 211, 212, 213, 216, 217, 218, 219, 220, 291

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
and control Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 06 Court Filings; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01, 02 and 07.							
Sexual Health, Sexually Transmitted Infections & Blood-borne Infections, including HIV							
ID 09 Sexual Health Promotion This record series contains information related to health promotion and policy development initiatives related to sexual health promotion. Includes: correspondence, campaigns, training and curriculum resources, registration forms, consultations, Health Unit published reports, dissemination strategies, advocacy for healthy public policies, activity tracking, literature and	Originating Program or Service	C+1	5	C+6	AR, Protected, PI		198, 218

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

ID – Infectious Diseases

– includes records of programs and services to reduce the burden of infectious diseases of public health importance (OPHS, 2008, p. 30).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
resource materials related to sexual health promotion. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01-07.							
Tuberculosis Prevention & Control							
ID 10 Tuberculosis Prevention and Control This record series contains information related to health promotion and policy development initiatives and disease prevention and health protection activities related to tuberculosis prevention and control. Includes: correspondence, campaigns, training and curriculum resources, registration forms,	OHCDSHS	C+1	5	C+6	PI, AR Protected		20, 51, 53, 55, 178, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 198, 201, 203, 204, 211, 212, 213, 216, 217, 218, 219, 220, 291

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
consultations, Health Unit published reports, dissemination strategies, advocacy for healthy public policies, activity tracking, literature and resource materials related to tuberculosis prevention and control. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 06 Court Filings; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 06.							
Vaccine Preventable Diseases							
ID 11 Vaccine Preventable Diseases (VPD) This record series contains information related to health promotion and policy development initiatives and disease prevention and health protection activities related to vaccine	OHCDSHS	C+1	5	C+6	PI, AR Confidential	Fridge Logs are required to process vaccine orders. If the temperature readings fall outside the recommended	7, 8, 19, 20, 51, 53, 55, 178, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 198, 204, 214, 215, 218, 219, 220, 286,

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
preventable diseases. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to vaccine preventable diseases. Excludes: Premise Cold Chain Inspections – see ID 07; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 06 Court Filings; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 06.						range i.e. 2-8º Celsius, the Fridge Log is filed in the office/facility file and retained until the annual site inspection is completed. For Fridge Logs that document acceptable readings, the log is considered S/O and will be confidentially shredded when the order is processed.	287, 288, 291

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

EH – Environmental Health

– includes records of programs and services which prevent or reduce the burden of food-borne illness, water-borne illness and injury related to recreational water use and illness from health hazards in the physical environment (OPHS, 2008, pgs 42, 44, 46).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
EH 01 Environmental Health General This record series contains Environmental Health records which cannot be classified elsewhere. Use only if no other heading is available.	EHCDPS OHCDSHS	C+1	2	C+3	Protected		
EH 02 Population Health Assessment This series includes information related to measuring, monitoring and reporting the status of a population's health related to health behaviours, risks and trends associated with environmental health. Includes: correspondence, health statistics, data access, collection and management, data sets and analysis, technical notes, graphs, tables, maps, socio-demographic reports and health status reports, factsheets, reporting and dissemination strategies and related information. Excludes: contact tracing and program surveillance conducted by program staff; AD 03	EHCDPS OHCDSHS	C+2	5	C+7	PI, AR, VR, Confidential	P= Demographic & Health Status Reports Retention of Fact Sheets determined on a case by case basis	

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EH – Environmental Health

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
EH 03 Surveillance This series contains information related to epidemiological analysis of surveillance data including monitoring trends over time, emerging trends and priority populations related to environmental health. Includes: correspondence, assessment and surveillance data, analysis, technical notes, graphs, tables, maps, socio-demographic and health status reports, fact sheets, dissemination strategies, activity tracking, literature and resource materials and correspondence related	EHCDPS OHCDSHS	C+2	5	C+7	PI, AR, VR, Confidential	P= Demographic & Health Status Reports Retention of Fact Sheets to be determined on a case by case basis	

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
to environmental health. Excludes: contact tracing and surveillance conducted by program staff; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
EH 04 Research & Knowledge Exchange This series includes records related to identifying research questions, networking with community researchers, academic partners and others to support applied public health research and knowledge exchange and research undertaken by MLHU or in partnership with others related to environmental health. Includes: correspondence, ethics and internal	EHCDPS OHCDSHS	C+2	5	C+7*	PI, AR, VR, Confidential	P= reports to be determined on a case by case basis * total retention for funded projects is based on the requirements of the funding agency	7, 8, 258

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
reviews, credentials of external investigators, project plans, data collection tools, findings, resources developed, reports, dissemination strategies, annual summaries of research undertaken. Excludes: presentations at conferences see AD 04; for staff development related to research and knowledge exchange see HR 11; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for Orientation & Staff Development / Training see HR 11.							
EH 05 Program Evaluation This series contains records related to program evaluations, including needs assessments related to environmental health. Includes: correspondence. evaluation project plans, data collection tools, evaluation data,	EHCDPS OHCDSHS	C+2	5	C+7*	PI, AR, VR, Confidential	P = Reports to be determined on a case by case basis *Total retention for funded research projects is based on requirements of	7, 8, 258

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
literature searches and references, findings, reports, dissemination strategies, Excludes: Grant Funding see AC 10; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration ; for conference presentations see AD 04; for staff development / training related to program evaluation including needs assessment see HR 11.						funding agency.	
Food Safety							
EH 06 Food Safety This record series contains information related to health promotion and policy development initiatives and disease prevention and health protection activities related to the MLHU Food Safety Program, which focuses on routine inspections of food establishments, recall checks, responses to consumer complaints and follow-up related to food-borne illness and	EHCDPS OHCDSHS	E+2	5	E+7	PI, AR, VR, Confidential	E=Resolution of the investigation P=Inspector notebooks	7, 8, 57, 58, 59, 60, 61, 62, 63, 118, 119, 120, 121, 123, 124, 149, 150, 155, 211, 212, 213, 290

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
disclosure of inspection findings to the public. Includes: correspondence, campaigns, consultations, Approval for Special Occasion Food Service, Liquor License, Municipal Business Licenses and Farmer's Market permits, field reports, activity tracking, food recall notices, complaints, Food Handler training program, registration forms inspector notebooks, Food Bacteriological results, distribution lists, Health Unit published reports, dissemination strategies, advocacy for healthy public policies, activity tracking, Hedgehog, literature, resource materials and associated work plans related to food safety. Excludes: Outbreak files see CF 02 Client Records; see ID 07 for Infectious Disease Control Premise Inspections; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 06 Court Filings, AD 09 Operational and Program Planning; AD 10							

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01,02, 07.							
Safe Water							
EH 07 Safe Water This record series contains information related to health promotion and policy development initiatives and disease prevention and health protection activities focusing on reducing the burden of water-borne illness related to drinking water and preventing or reducing the burden of water-borne illness and injury related to recreational water use i.e. public pools, spas and beaches. Includes: correspondence, campaigns, training and curriculum resources, registration forms, consultations, Health Unit published reports,	EHCDPS	C+2	4	C+6	PI, AR, VR, Confidential	P = Inspector Notebooks SDWS: Retain for 99 years	56, 93, 94, 95, 96, 97, 98, 107, 108, 109, 110, 111, 112, 113, 114, 118, 119, 120, 121, 124, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 199, 206, 209,

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials and associated work plans related to safe water, requests for inspection, lab results, drinking and boil water advisories to home/business owners and orders, inspector notebooks, statistics and reporting; Hedgehog, private water system results (WITSEN) and small drinking water systems program related information. Excludes: AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 06 Court Filings; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client records see CF 01, 02, 07.							210, 211, 212, 213

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Health Hazard Prevention & Management							
EH 08 Health Hazard Prevention and Management This record series contains information related to health promotion and policy development initiatives and disease prevention and health protection activities related to Health Hazard Investigations as defined in the Health Protection and Promotion Act. This classification includes all investigations that do not fall under a specific program including biological, physical and chemical agents, natural or man-made. This series also contains information relating to special events e.g. Children's Festival etc., hot and cold weather responses and pesticides. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies,	OMOH EHCDPS [1] OHCDSHS (disinterment)	E+2	5	E+7	PI, VR, Confidential	E=Resolution of Investigation P=Inspector notebooks * *Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	27, 113, 114, 115, 118, 119, 120, 121, 124, 125, 126, 127, 149, 150, 155, 211, 212, 213, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 281, 282, 284, 285

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Method of Disposal:

- **Paper:** records containing confidential information, i.e. identifying personal, personal health information, to be placed in locked bins for confidential shredding
- **Electronic:** all versions to be deleted from all network drives and USB keys; CDs, floppy diskettes, audio and video media to be placed in specially designated locked bins for confidential destruction

Programs and service delivered by MLHU classified by the Ontario Public Health Standards

EH – Environmental Health

– includes records of programs and services which prevent or reduce the burden of food-borne illness, water-borne illness and injury related to recreational water use and illness from health hazards in the physical environment (OPHS, 2008, pgs 42, 44, 46).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
activity tracking, literature, resource materials and associated work plans related to health hazards, Hedgehog, complaints, inspector notebooks, distribution lists, emissions results, environmental assessments, air quality exceedance reports, aerial spraying notices, hazardous products, housing and living conditions, industrial waste, Polychlorinated Biphenyls (PCB), disinterment[1], hot and cold weather alerts and pesticides. Excludes: ID 06 Infectious Diseases Prevention and Control for complaints related to Infection Control aspects in institutions, day cares; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 06 Court Filings; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; for Orientation & Staff Development / Training see HR 11; for client							

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
records see CF 01, 02, 07.							
EH 09 Part 8/Ontario Building Code (Septic Systems) (This program was terminated at the end of 1992. Retention applies to existing records). This record series contains information gathered on septic systems under Part 8 of the Ontario Building Code. It reflects the initial, substantial and graded inspections and permitting of septic systems for new construction, renovations or land severances. Includes: OBC application kit; consent, minor variance and zoning information, Sewage System User Fee Schedule, Ontario Building Code Act, Copy of a Record, complaints, inspector notebooks, program related information from the Ministry of the Environment, Ministry of Municipal Affairs and Housing and general contractors, Ontario	EHCDPS	E+2	97	E+99	AR, VR, Confidential	E = date of repeal P = Inspector Notebooks	80, 81, 82, 83, 84, 87, 92, 100, 116, 117, 118, 119, 120, 121, 124, 126, 127, 155, 156,

Draft Classification System / Retention Schedule – April 1, 2011

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Building Code Act Examination. Excludes: Court files, orders, subpoenas see AD 06; By-laws see Board of Health Committee and Standing Committee of the Board CR 05.							

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

EP – Emergency Preparedness

– includes records of programs and services to enable and ensure a consistent and effective response to public health emergencies and emergencies with public health impacts (OPHS, 2008, p. 43).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
EP 01 Public Health Emergency Preparedness General This record series contains Public Health Emergency Preparedness records which cannot be classified elsewhere. Use only if no other heading is available.	OMOH	C+1	2	C+3	Protected		
EP 02 Population Health Assessment This series includes information related to measuring, monitoring and reporting the status of a population's health related to health behaviours, risks and trends related to emergency preparedness. Includes: correspondence, health statistics, data access, collection and management, data sets and analysis, technical notes, graphs, tables, maps, socio-demographic reports and health status reports, factsheets, reporting and dissemination strategies and related information. Excludes: contact tracing and program surveillance conducted by program staff; AD 03	OMOH	C+2	5	C+7	PI, AR, VR, Confidential	P= Demographic & Health Status Reports Retention of Fact Sheets determined on a case by case basis	

Draft Classification System / Retention Schedule – April 1, 2011

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EP – Emergency Preparedness

– includes records of programs and services to enable and ensure a consistent and effective response to public health emergencies and emergencies with public health impacts (OPHS, 2008, p. 43).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
EP 03 Surveillance This series contains information related to epidemiological analysis of surveillance data including monitoring trends over time, emerging trends and priority populations related to emergency preparedness. Includes: correspondence, assessment and surveillance data, analysis, technical notes, graphs, tables, maps, socio-demographic and health status reports, fact sheets, dissemination strategies, activity tracking, literature and resource materials and correspondence related to emergency preparedness.	OMOH	C+2	5	C+7	PI, AR, VR, Confidential	P= Demographic & Health Status Reports Retention of Fact Sheets to be determined on a case by case basis	

Draft Classification System / Retention Schedule – April 1, 2011

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EP – Emergency Preparedness

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Excludes: contact tracing and surveillance conducted by program staff; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; for conference presentations see AD 04; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for Orientation & Staff Development / Training see HR 11.							
EP 04 Research & Knowledge Exchange This series includes records related to identifying research questions, networking with community researchers, academic partners and others to support applied public health research and knowledge exchange and research undertaken by MLHU or in partnership with others related to emergency preparedness. Includes: correspondence, ethics and internal reviews, credentials of external investigators, project plans, data collection tools, findings, resources developed, reports, dissemination	OMOH	C+2	5	C+7*	PI, AR, VR, Confidential	P= reports to be determined on a case by case basis * total retention for funded projects is based on the requirements of the funding agency	7, 8, 258

Draft Classification System / Retention Schedule – April 1, 2011

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

EP – Emergency Preparedness

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
strategies, annual summaries of research undertaken. Excludes: presentations at conferences see AD 04; for staff development related to research and knowledge exchange see HR 11; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for Orientation & Staff Development / Training see HR 11.							
EP 05 Program Evaluation This series contains records related to program evaluations, including needs assessments related to emergency preparedness. Includes: evaluations of emergency events, mock exercises, evaluation project plans, data collection tools, evaluation data, literature searches and references, findings, recommendations, reports, dissemination strategies.	OMOH	C+2	5	C+7*	PI, AR, VR, Confidential	P = Reports to be determined on a case by case basis *Total retention for funded research projects is based on requirements of funding agency.	7, 8, 258

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Programs and service delivered by MLHU classified by the Ontario Public Health Standards

EP – Emergency Preparedness

– includes records of programs and services to enable and ensure a consistent and effective response to public health emergencies and emergencies with public health impacts (OPHS, 2008, p. 43).

Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
Excludes: Grant Funding see AC 10; AD 03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for conference presentations see AD 04; for staff development / training related to program evaluation including needs assessment see HR 11.							
EP 06 Emergency Preparedness This series contains information related to health promotion and policy development initiatives focusing on emergency preparedness and health protection activities related to emergency planning i.e. information related to a continuity of operations plan, emergency response plan. Includes: correspondence, campaigns, training and curriculum resources, including presentations, registration forms, consultations, *Health Unit published resources**, dissemination strategies, advocacy for healthy public policies, activity tracking, literature, resource materials	OMOH	C+1	5	C+6	AR, Protected, PI	** Published works are not records. A copy of in-house reports is to be forwarded to the Health Unit Library*	

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Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
e.g. Emergency Response Plans from the City of London, Middlesex County & County Municipalities, Conservation Authorities and hospitals etc. and associated work plans related to emergency preparedness <u>Excludes:</u> AD03 Committees, Meetings, Agencies, Groups & Task Forces; AD 09 Operational and Program Planning; AD 10 Policies, Procedures, Manuals & Guidelines Administration; for funded research proposals see AC 10 Grant Funding; for conference presentations see AD 04; see CM 05 for Media; see CM 06 for Newsletters; see CM 07 for Promotional and Educational Materials; for Orientation & Staff Development / Training see HR 11							

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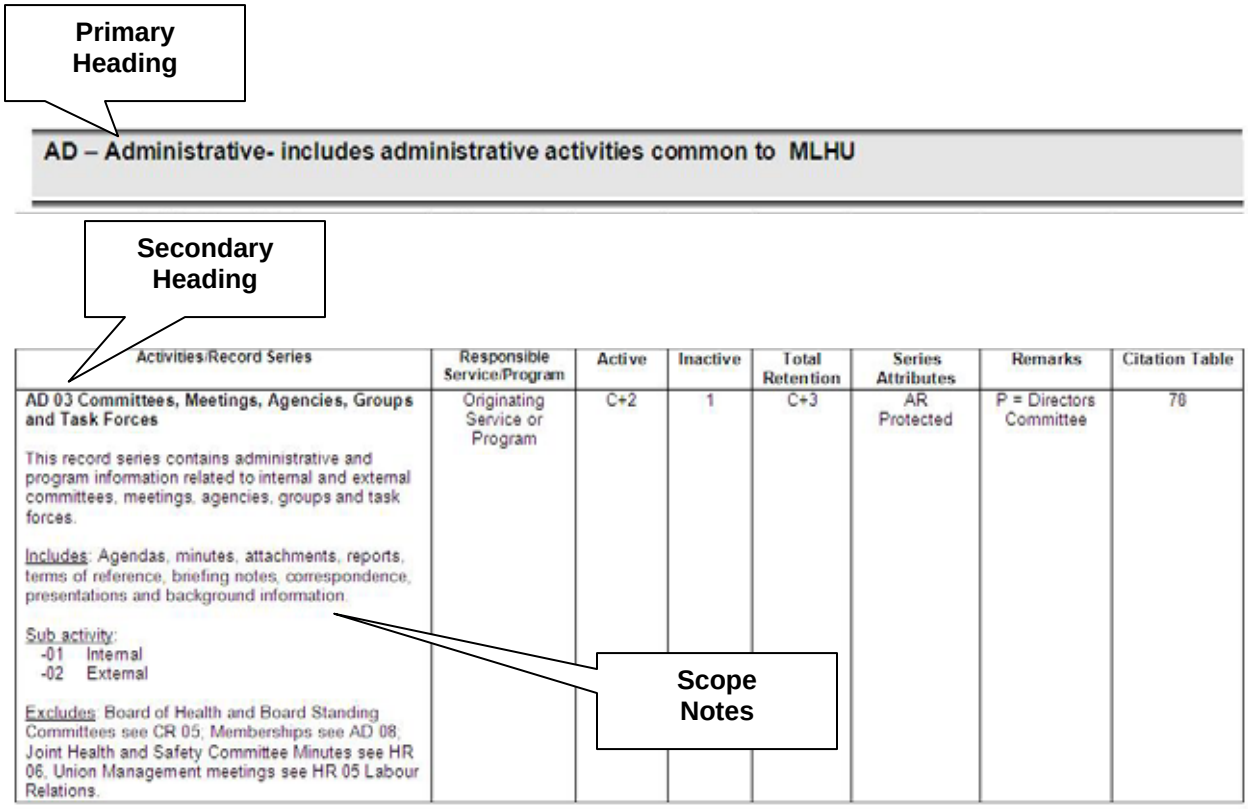
Program & Services /Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
EP 07 Emergency Contact Lists This record series includes contact information to be used during an emergency or during a "test" exercise to assess the process and Health Unit capacity to respond to an emergency. -01 Internal i.e. staff -02 External i.e. other agencies -03 Clients at Risk	OMOH	S/O	-	S/O	Restricted, PI		

APPENDIX A: INTERPRETING THE CLASSIFICATION SYSTEM/RETENTION SCHEDULE

EXAMPLE: AD03 COMMITTEES, MEETINGS, AGENCIES, GROUPS AND TASK FORCES



Activities/Record Series	Responsible Service/Program	Active	Inactive	Total Retention	Series Attributes	Remarks	Citation Table
AD 03 Committees, Meetings, Agencies, Groups and Task Forces This record series contains administrative and program information related to internal and external committees, meetings, agencies, groups and task forces. Includes: Agendas, minutes, attachments, reports, terms of reference, briefing notes, correspondence, presentations and background information. Sub activity: -01 Internal -02 External Excludes: Board of Health and Board Standing Committees see CR 05; Memberships see AD 08; Joint Health and Safety Committee Minutes see HR 06; Union Management meetings see HR 05 Labour Relations.	Originating Service or Program	C+2	1	C+3	AR Protected	P = Directors Committee	70

DEFINITIONS

General – each primary heading, e.g. Administrative (AD) has a "General" secondary heading, i.e. AD01 Administrative General. This should be used only if the record can not be classified elsewhere.

Scope Notes: each record series i.e. grouping of similar records includes a brief description including examples of the types of records included and those excluded i.e. classified under another records series. Examples are intended to offer direction and do not list every possible record.

Responsible Service/Program: identifies which program or service area is responsible for the official record, i.e. Record Steward. Other copies are considered transitory.

Retention Periods – are based on legislative requirements and where there are no requirements are based on best practices. Retention periods are listed as active, inactive and total retention:

- **Active –** records are consulted frequently and need to be in close proximity. **Decision Point:** for the beginning of the "active" period, the record most likely will be kept in the Service Area. For the remainder of the active period, paper records can be stored in the Health Unit Records Room – secure access, located on the Lower Level.
- **Inactive** – records are consulted infrequently. **Decision Point:** depending on the frequency of access required and the length of the retention period, inactive records may be stored in the Health Unit Records Room or in off-site storage. If an off-site record is required, it can be retrieved from the contactor for Off-Site Storage. Cost is dependent on the response time. Tip: it is more cost effective to store records off-site than to use prime office space.
- **Total Retention** – calculates the total retention period.
- **Permanent** – some records e.g. Board of Health business and some Communicable Disease and Sexual Health client records are retained permanently. **Decision Point:** depending on the frequency of access required, off-site storage is the preferred option.

Retention Codes

C = Current Year; **E** = Event; **P** = Permanent; **PI** = Personal Information.

Series Attributes

AR = Records subject to Archival Selection – these records are considered permanently valuable and contain information about MLHU's history, organization, structure and functions, e.g. significant contracts, organizational changes, memorabilia, photographs. Typically a small number of records meet this criteria e.g. two to five percent.

S/O = Superseded/Obsolete – record is replaced with an updated version or is no longer relevant.

VR = Vital Records – records required by an organization to continue functioning in the event of a disaster.

Unrestricted – no restrictions apply

Confidential – information is available only to a specific function, group or role.

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Remarks – identifies additional information

Citation Table – the final column references by number the relevant legislation. This is captured in a separate document.

APPENDIX B: OFFICIAL & TRANSITORY RECORDS

OFFICIAL

- ongoing value or required for legal, financial, operational, historical or other official obligations

Examples

- evidence of Health Unit business
- policy & planning activities
- recommendations & decisions
- interactions e.g. clients, consultants, etc.
- legal & contractual agreements
- financial & service obligations

STOP!

Retain according to the Retention Periods.

Review for archival value prior to disposing.

Must be retained until Freedom of Information (FOI) request or legal action resolved.

TRANSITORY

- temporary, i.e. immediate or very short term usefulness
- not required for legal, financial, operational or official obligations

Examples

- miscellaneous notices
- multiple copies
- preliminary drafts
- published information
- personal notes with no work-related value

Destroy/delete unless…
FOI request or legal action

APPENDIX C: CITATION TABLES

Citation Tables: List both legislative and non-legislative requirements that govern retention periods.

The MLHU Classification System/Retention Schedule (CS/RS) builds on the work done by the Sudbury & District Health Unit (SDHU). In November 2010, SDHU granted MLHU permission to use and/or modify their documents.

The attached SDHU Citation Tables has been used to inform retention periods for MLHU documents.

Overview — The Citation Tables provide all of the relevant legislative and non-legislative citations which apply to the Secondary Activities identified in the Classification Scheme / Retention Schedule.

Jurisdictions Covered

In researching the legislative requirements for the SDHU's records, only the Canadian Federal and Ontario Provincial jurisdictions were reviewed.

Release 3 of FileLaw 2010 was used to research the statutes and regulations listed below. FileLaw™ is the electronic edition of Carswell's product Records Retention, Statutes & Regulations. With this release the Federal contents of FileLaw™ have been updated to June 29, 2010 for the Statutes of Canada and June 23, 2010 for the regulations. Ontario contents have been updated to December 15, 2009 for the Statutes of Ontario and December 26, 2009 for the regulations.

Number	FileLaw™ Entry Code	Federal Citations	Retention/Limitation
1	FF-Exc.Tx.-4	Excise Tax Act, R. S. C. 1985, c. E-15, s. 98.(1), as am. R. S. C. 1985 (1st Supp.), c. 15, s. 36; as am. R. S. C. 1985 (2nd Supp.), c. 7, s. 45.(1); ss. 100.(2) to (4); as am. S. C. 2002, c. 22, s. 386 Excise Tax Records and Books of Account	Event + 6 years (Event = End of calendar year for which records kept; or until written permission for prior disposal by Minister given; or longer if appeal) Event + 6 years (Event = End of calendar year for which records kept; or until written permission for prior disposal by Minister given; or longer if appeal)
2	FBS-Exc.Tx.-15	Excise Tax Act, R. S. C. 1985, c. E-15, s. 102 Offences Regarding Records	Not specified Non records–related entry deleted after editorial review.
3	FBS-Excis01-8	Excise Act, 2001, S. C. 2002, c. 22, s. 206; as am. S. C. 2008, c. 28, s. 59 Records and Information Retention	Event + 6 years (Event = End of year to which relate, or for any prescribed period; in English or French)
4	FBS-Excis.-2	Excise Act, R. S. C. 1985, c. E-14, s. 33.(1); s. 31; as am. S. C. 1999, c. 17, s. 144.(1)(h) Excise Accounting Records	Event + 6 years (Event = End of calendar year for which kept; or earlier if written permission given by Minister)
5	FBS-Excis.-5	Excise Act, R.S.C. 1985, c. E-14, s. 122 Excise Offence Prosecutions — Limitation Period	Event + 2 years (Event = Time matter of information or complaint arose)
6	FBS-Tra.Mr.-1	Trade-marks Act, R.S.C. 1985, c. T-13, s. 40(2); as am. S.C. 1993, c. 15, s. 68; S.C. 1993, c. 44, ss. 231(1), 236(1)(i); s. 40(3); as am. S.C. 1993, c. 44, s. 231(2) Application for Registration of a Proposed Trade-mark — Limitation	Three years after the date of filing of the application in Canada
7	FC-PIPED-1	Personal Information Protection and Electronic Documents Act, S. C. 2000, c. 5, s. 37 Electronic Documents	Event = Retain for specified period in format made, sent or received, so can be read, and with information that identifies origin and destination
8	FC-PIPED-13	Personal Information Protection and Electronic Documents Act, S. C. 2000, c. 5, Schedule 1, Principle 4.5 Schedule 1 National Standard Model Code	Event = Retain only as long as necessary for fulfilment of purposes
9	FF-In.Tx.-1	Income Tax Act, R. S. C. 1985, c. 1 (5th Supp.), s. 150.1.(4); as am. S. C. 1994, c. 21, s. 75; as am. S. C. 2001, c. 17, s. 148; as am. S. C. 2009, c. 2, s. 57 Electronic Tax Records Filing	Not specified
10	FF-In.Tx.-13	Income Tax Act, R. S. C., 1985, c. 1 (5th Supp.), s. 230; as am. S. C. 1994, c. 21, s. 105; as am. S. C. 1998, c. 19, s. 227 Taxpayer Records	Event + 6 years (Event = end of last taxation year to which records and books of account relate, or year return filed, as long as no other exceptions apply)
11	FF-In.Tx.-15	Income Tax Act, R. S. C., 1985, c. 1 (5th Supp.), s. 244.(4) Summary Conviction Proceedings — Limitation Period	8 years

Number	FileLaw™ Entry Code	Federal Citations	Retention/Limitation
12	FF-In.Tx.-16	Income Tax Act, R. S. C., 1985, c. 1 (5th Supp.), s. 207.(2)(b) Refunds by Minister — Limitation Period	Event + 3 years (Event = mailing of original notice of assessment for year)
13	FF-In.Tx.-4	Income Tax Regulations, under the Income Tax Act, C. R. C. 1978, c. 945, s. 5800.(1)(c); as am. SOR/82-879, s. 2; as am. SOR/94-686, ss. 51.(F), 79.(F) General Ledger or other Book of Final Entry containing Summaries of Year–to–Year Transactions of Business of Person other than Corporation	Event + 6 years (Event = end of last day of taxation year of person in which business ceased)
14	FPH-CDS-27	Benzodiazepines and Other Targeted Substances Regulations, under the Controlled Drugs and Substances Act, SOR/2000-217, ss. 40, 46 Export and Import Permit Holders — Declarations	Keep to provide minister on request within 15 days of release
15	FPH-CDS-3	Benzodiazepines and Other Targeted Substances Regulations (1991), under the Controlled Drugs and Substances Act, SOR/2000-217, ss. 9, 51.(3) Pharmacists — Targeted Substance Verbal Prescription Records	Event + 2 years (Event = Day information obtained or last transaction recorded)
16	FPH-CDS-4	Benzodiazepines and Other Targeted Substances Regulations (1991), under the Controlled Drugs and Substances Act, SOR/2000-217, ss. 9, 55.(2) to (4) Pharmacists — Provision, Transport, Sale of Targeted Substance without Prescription or on Verbal Orders Records	Event + 2 years (Event = Day information obtained or last transaction recorded)
17	FHC-CDS-5	Narcotic Control Regulations, under the Controlled Drugs and Substances Act, C. R. C. 1978, c. 1041, ss. 54, 55.(a),(b),(c),(e); as am. SOR/2004-237, s. 21 Practitioners — Narcotics Sale Records	2 years
18	FPH-Fd.Dr.-38	Food and Drug Regulations, under the Food and Drugs Act, C. R. C. 1978, c. 870, s. C.01.043.(2) Schedule F Drugs Prescribed Sales Records	Event + 2 years (Event = date of filling order)
19	FHC-Quar-1	Quarantine Regulations, under the Quarantine Act, C. R. C., c. 1368, ss. 9.(1),(2) Vaccination Against Small Pox Evidence	Keep to provide on request
20	FHC-Quar-2	Quarantine Regulations, under the Quarantine Act, C. R. C., c. 1368, s. 11 Vaccination Against Yellow Fever Evidence	Keep to provide on request
21	FLA-Copy.-24	Educational Program, Work and Other Subject-matter Record-keeping Regulations, under the Copyright Act, SOR/2001-296, ss. 6-9 Institution Copying Information Record	Event + 2 years (Event = copy destroyed unless original information send to collective society within that time)

Number	FileLaw™ Entry Code	Federal Citations	Retention/Limitation
22	FLA-Copy.-25	Exception for Educational Institutions, Libraries, Archives and Museums Regulations , under the Copyright Act, SOR/99-325, s. 4 Library, Archive or Museum - Copying Records	3 years
23	FLA-Copy.-26	Exception for Educational Institutions, Libraries, Archives and Museums Regulations , under the Copyright Act, SOR/99-325, s. 5 Archive Copying Record under Copyright Act, s. 30.21.(5)	3 years Section repealed SOR/2008-169, s. 5
24	FLA-Tra.Mr.-2	Trade-marks Act, R.S.C. 1985, c. T-13, s. 45(3); as am. S.C. 1993, c. 44, s. 232(2); S.C. 1994, c. 47, s. 200(2) Trade-mark Non-use — Limitation	Three year period immediately preceding the date of the notice
25	FLA-Tra.Mr.-3	Trade-marks Act, R.S.C. 1985, c. T-13, s. 26; as am. S.C. 1993, c. 44, s. 227 Trade-mark Register	Not specified
26	FLA-Tra.Mr.-4	Trade-marks Act, R.S.C. 1985, c. T-13, s. 45(1); as am. S.C. 1993, c. 44, s. 232(1); S.C. 1994, c. 47, s. 200(1) Trade-mark Use Evidence — Limitation	Three years from the date of the registration of a trade-mark
27	FS-HMIR-1	Hazardous Materials Information Review Act, R.S.C. 1985 (3rd Supp.), c. 24, Pt. III, s. 49(3) Hazardous Materials Summary Conviction Offence Prosecutions — Limitation Period	1 year

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
51		College of Nurses of Ontario Practice Standard Documentation Pub. No. 41001 Copyright © College of Nurses of Ontario, 2005	Retention of Health Records Legislation requires that most practice settings retain health records for a minimum of 10 years after the client was last assessed or treated. The health records of clients under age 18 at the time of last assessment/treatment must be retained for a minimum of 10 years from the day the client turns 18.
52		College of Dietitians of Ontario Records Keeping Guidelines for Registered Dietitians 2004 Copyright 2004 ©	A client record should be kept for at least 10 years since the latter of: • The client's last visit; or • The date at which the client turned 18. A record should be maintained of when each client chart was destroyed noting the name of the client, any file number, the date of last treatment and the date the file was destroyed.
53		The College of Physicians and Surgeons of Ontario	Regulation requires that physicians keep medical records for a certain period of time. For adult patients, the rule is that records must be retained for 10 years from the date of the last entry in the record. For patients who are children, the regulation requires that the physician keep the record until 10 years after the day on which the patient reached or would have reached the age of 18 years. However, it is prudent to maintain records for a minimum of 15 years because, in accordance with the *Limitations Act*, some legal proceedings against physicians can be brought 15 years after the act or omission on which the claim is based took place.

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
54		Royal College of Dental Surgeons of Ontario	The recordkeeping regulations made under the Dentistry Act, 1991 requires that clinical, financial and drug records that are made in respect to an individual patient must be maintained for at least 10 years from the date of the last entry in that record. In the case of a minor, these records must be kept for at least 10 years after the day on which the patient reached the age of 18 years. Two exceptions to this requirement involve
55	OHC-HPP-11 Duplicate entry see OHC-HPP-10 #195	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, s. 38.(3) Physicians and Nurses — Reportable Events / Immunization Reports	Not specified
56	OMUN-HPP-3	Public Pools Regulation, under the Health Protection and Promotion Act, R. R. O. 1990, R. 565, ss. 7.(10),(11),(13) Chlorine or Bromine Residual and pH Value Tests / Chemical and Water Records	Not specified
57	OAF-FSQ.-1	Food Safety and Quality Act, 2001, S. O. 2001, c. 20, s. 41.(3) Food Safety and Quality Act, 2001/ Regulations Offence — Limitation Period	Event + 2 years (Event = later of : day contravention or failure occurred and: day evidence first came to attention of director)
58	OAF-FSQ.-11	Meat Regulation, under the Food Safety and Quality Act, 2001, O. R. 31/05, s. 80.(2) Post Mortem Inspection Identification Record	Not specified
59	OAF-FSQ.-15	Meat Regulation, under the Food Safety and Quality Act, 2001, O. R. 31/05, s. 95 Laboratory Problem Examination Results	Not specified
60	OAF-FSQ.-2	Food Safety and Quality Act, 2001, S. O. 2001, c. 20, s. 45 Food Safety and Quality Act, 2001/ Regulations Offence — Limitation Period	Event + 2 years (Event = later of : day contravention or failure occurred and: day evidence first came to attention of director)

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
61	OAF-FSQ.-23	Food Safety and Quality Act, 2001, S. O. 2001, c. 20, ss. 39.(3) to (8), 40; as am. S. O. 2007, c. 4, ss. 31, 45.(2) Access to Food Quality Information	PRIVACY
62	OAF-HPP-1	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, ss. 16.(4),(5) Food Premises Operators — Manufacturing, Processing, Preparation, Storage, Handling, Display, Transportation and Sale Records	Event = Shall keep for such time as prescribed by regulations
63	OAF-HPP-8	Food Premises Regulation, under the Health Protection and Promotion Act, R. R. O. 1990, R. 562, s. 2.(3); as en. O. R. 308/06, s. 2.(2) List of Donors and Notice of Exemption Posting	Not specified
64	OBF-Insu.-4	Insurance Act, R. S. O. 1990, c. I.8, s. 148.(2), Stat. Cond. 14 Fire Insurance Claims — Limitation Period	1 year
65	OBF-Insu.-6	Insurance Act, R. S. O. 1990, c. I.8, s. 449; as am. S. O. 1997, c. 28, s. 147 Insurance Offence Prosecutions — Limitation Period	2 years
66	OF-Corp.Tx.-14	Corporations Tax Act, R. S. O. 1990, c. C.40, s. 91; as am. S. O. 2001, c. 23, s. 58; as am. S. O. 2004, c. 16, s. 2.(2) Application for Extension of Time for Notice of Objection or Appeal — Limitation Period	Event + 1 year (Event = mailing of notice of assessment that is subject of objection unless explanation satisfactory to the Minister is provided and Minister agrees to the extension of time)
67	OF-Corp.Tx.-15	Corporations Tax Act, R. S. O. 1990, c. C.40, s. 108.(1) Failure to Pay Taxes Notices of Property Sale Claim — Limitation Period	Event + 3 years (Event = date of mailing of notice of assessment or reassessment)
68	OF-Corp.Tx.-1	Corporations Tax Act, R. S. O. 1990, c. C.40, s. 94 Corporations Tax Offences — Limitation Period	Not specified “shall keep”
69	OF-Corp.Tx.-5	Corporations Tax Act, R. S. O. 1990, c. C.40, s. 82.(1); as am. S. O. 1994, c. 14, s. 40.(1); as am. S. O. 2004, c. 16, s. 2.(2) Tax Return Refund Overpayment Claim — Limitation Period	Event + 4 years (Event = end of taxation year)
70	OF-Corp.Tx.-7	Corporations Tax Act, R. S. O. 1990, c. C.40, s. 13.3.(10); as am. S. O. 1998, c. 34, s. 31; as am. S. O. 2004, c. 16, s. 2.(2) Workplace Accessibility Tax Incentive Certificates	Not specified
71	OF-Corp.Tx.-9	Corporations Tax Act, R. S. O. 1990, c. C.40, s. 43.13.(18); as am. S. O. 2004, c. 31, Schedule 9, s. 22 Apprenticeship Contracts or Training Agreements	Not specified

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
72	OF-Corp.Tx.-10	Corporations Tax Act, R. S. O. 1990, c. C.40, s. 43.4.(5); as am. S. O. 1996, c. 29, s. 49.(3); as am. S. O. 1997, c. 43, Schedule A, s. 18.(3); as am. S. O. 2004, c. 16, s. 2.(2) Certificates of Qualifying Work Placements	Not specified
73	OF-Corp.Tx.-11	Corporations Tax Act, R. S. O. 1990, c. C.40, ss. 75.(6) to (6.3); as am. S. O. 1994, c. 14, s. 33.(8); as am. S. O. 2004, c. 16, s. 2.(2) Certificates that Return Information and Documents are in Agreement with Records and Books of Account	Not specified
74	OF-RST-50	Definitions, Exemptions and Rebates Regulation, under the Retail Sales Tax Act, R. R. O. 1990, R. 1012, s. 6.(11); as am. O.R. 162/95, s. 3 Invoices	Not specified
75	OC-Bs.Corp.-3	Business Corporations Act, R. S. O. 1990, c. B. 16, s. 104.(2); as am. S. O. 2000, c. 26, Schedule B, ss. 3.(5),(6) Resolutions	Not specified REMOVE
76	OC-Bs.Corp.-37	General Regulations, under the Business Corporations Act, R. R. O. 1990, R. 62, s. 24.1.(2)(b) Electronic Format Requirements/ NUANS Report / Consents	Not specified REMOVE
77	OC-Corp.-1	Corporations Act, R. S. O. 1990, c. C. 38, ss. 300 par. 2, 304.(1)(part),(2),(3), 305.(1)(part) Corporations By-Laws and Special Resolutions	Not specified
78	OC-Corp.-4	Corporations Act, R. S. O. 1990, c. C. 38, ss. 299.(1), 304.(1)(part),(2),(3), 305.(1)(part) Corporations — Meetings Minutes of Proceedings	Not specified
79	OC-El.Cm.-1	Electronic Commerce Act, 2000, S.O. 2000, c. 17, s. 12 Electronic Information/Documents	Not specified
80	OCON-Bl.Cd.-10	Building Code Regulation, (Part V), under the Building Code Act, 1992, O. R. 350/06, Division C, s. 3.2.6.1.(1) Public Register of Sewage System Contractors	Not specified
81	OCON-Bl.Cd.-15	Building Code Act, 1992, S. O. 1992, c. 23, s. 36.(8); as am. S. O. 2009, c. 33, Sched. 21, s. 2.(9) Building Code Act Offence Prosecutions — Limitation Period	Event + 1 year (Event = Facts first came to knowledge of officer or chief building official; as applicable)
82	OCON-Bl.Cd.-4	Building Code Act, 1992, S. O. 1992, c. 23, s. 3.1.(7); as am. S. O. 2002, c. 9, s. 7 Board of Health, Planning Board and Conservation Authority Building Code Act Records	Event = Retain as prescribed by regulation for prescribed period of time

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
83	OCON-Bl.Cd.-6	Building Code Regulation, (Part V), under the Building Code Act, 1992, O. R. 350/06, Division C, s. 1.3.2.1.(1) Posting of Construction/Demolition Permits	Not specified
84	OCON-Bl.Cd.-7	Building Code Regulation, (Part V), under the Building Code Act, 1992, O. R. 350/06, Division C, s. 1.3.2.2.(1) Contractors — Drawings, Specifications and Authorizations	Event = Keep and maintain on site of construction
85	OCON-OHS-1	Construction Projects Regulation, under the Occupational Health and Safety Act, O. R. 213/91, ss. 10, 19 Employers — Accident Records	Event + 1 year (Event = project finished)
86	OCON-OHS-21	Construction Projects Regulation, under the Occupational Health and Safety Act, O. R. 213/91, ss. 19, 93.(4); as am. O. R. 145/00, s. 25.(2) Machines / Equipment / Vehicles /Tool Manuals	Event + 1 year (Event = project finished)
87	OCON-OHS-27	Construction Projects Regulation, under the Occupational Health and Safety Act, O. R. 213/91, ss. 29.(9),(12); as am. O. R. 145/00, s. 15 Constructors — Record of Servicing, Cleaning and Sanitizing of Facilities and Facilities Location Change Documents	Event = Keep for duration of project
88	OCON-OHS-32	Construction Projects Regulation, under the Occupational Health and Safety Act, O. R. 213/91, s. 8, 9, 11, 12; as am. O. R. 145/00; as am. O. R. 85/04, s. 3 Accident Notices and Reports Format	Not specified
89	OCON-OHS-36	Construction Projects Regulation, under the Occupational Health and Safety Act, O. R. 213/91, s. 55 Fire Extinguisher Tag Date Inspection Records	Not specified
90	OCON-OHS-37	Construction Projects Regulation, under the Occupational Health and Safety Act, O. R. 213/91, s. 57.(12); as am. O. R. 145/00, s. 18.(2) Floor Plan	Not specified
91	OCON-OHS-58	Construction Projects Regulation, under the Occupational Health and Safety Act, O. R. 213/91, s. 248 Posting of Fire Alarm Notices	Not specified
92	OCON-OHS-6	Construction Projects Regulation, under the Occupational Health and Safety Act, O. R. 213/91, ss. 19, 236.(7) Design Drawings/Specifications	Event + 1 year (Event = project finished)

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
93	OCON-Wt.Rs.-3	Wells Regulation, under the Ontario Water Resources Act, R. R. O. 1990, R. 903, s. 12.1.(1); as am. O. R. 372/07, s. 12 Persons Contructing or Abandoning Wells — Log and Field Notes	Keep to make available on request
94	OCON-Wt.Rs.-4	Wells Regulation, under the Ontario Water Resources Act, R. R. O. 1990, R. 903, ss. 15.(10) par. 3, (11) par. b; as en. O. R. 372/07, s. 16 Person doing Chlorine Tests for Well Alterations — Written Instructions to Discontinue	2 years
95	OCON-Wt.Rs.-5	Wells Regulation, under the Ontario Water Resources Act, R. R. O. 1990, R. 903, s. 16.3.(1); as en. O. R. 372/07, s. 17 Single Well Records	2 years
96	OCON-Wt.Rs.-6	Wells Regulation, under the Ontario Water Resources Act, R. R. O. 1990, R. 903, ss. 16.4.(1),(3) to (5); as en. O. R. 372/07, s. 17 Well Clusters Records	Event = May complete one well record for group of wells
97	OCON-Wt.Rs.-7	Wells Regulation, under the Ontario Water Resources Act, R. R. O. 1990, R. 903, s. 16.5.(1); as en. O. R. 372/07, s. 17 Well Abandonment Records	Not specified
98	OCON-Wt.Rs.-8	Wells Regulation, under the Ontario Water Resources Act, R. R. O. 1990, R. 903, s. 14.11.(4)(c); as en. O. R. 372/07, s. 15 Well Tag Replacement Records	Not specified
99	OC-TSS-1	Elevating Devices Regulation, under the Technical Standards and Safety Act, 2000, O. R. 209/01, s. 30 Owners — Posting of Elevator Licences	Not specified
100	OC-TSS-11	Technical Standards and Safety Act, 2000, S. O. 2000, c. 16, s. 30.(1) Records, Documents, Plans, Log Books, Drawings, Instructions and Specifications	Event = Director may establish things to be kept
101	OC-TSS-13	Elevating Devices Regulation, under the Technical Standards and Safety Act, 2000, O. R. 209/01, s. 23 Contractors — Installation Lists and Lists of Contracts	Keep to make available on request
102	OC-TSS-2	Elevating Devices Regulation, under the Technical Standards and Safety Act, 2000, O. R. 209/01, ss. 33.(6),(7), 4.(2) Elevating Devices — Inspection and Tests Records Logbook	Event + 5 years (Event = Date of last entry)

Number	FileLaw™ Entry Code	Ontario Citations	Retention/Limitation
103	OC-TSS-3	Elevating Devices Regulation, under the Technical Standards and Safety Act, 2000, O. R. 209/01, s. 34; as am. O. R. 252/08, s. 19 Owner/Contractors — Elevating Device Log Books	Event + 5 years (Event = date of last entry)
104	OC-TSS-4	Elevating Devices Regulation, under the Technical Standards and Safety Act, 2000, O. R. 209/01, s. 37.(e); as am. O. R. 252/08, s. 22 Owners — List of Emergency Contacts	Keep to make available on request
105	OC-TSS-5	Elevating Devices Regulation, under the Technical Standards and Safety Act, 2000, O. R. 209/01, ss. 25.(2), 37.(f),(g) Owners — Elevating Device Design Submissions/ Maintenance Instructions	Keep to make available on request and transfer to new owners
106	OC-TSS-6	Elevating Devices Regulation, under the Technical Standards and Safety Act, 2000, O. R. 209/01, s. 38 Owners — Passenger Elevator Contractor Contacts	Keep to make available on request
107	OENV-Cl.Wt.-1	Clean Water Act, 2006, S. O. 2006, c. 22, ss. 15.(1), 20, 21.(1) to (5) Assessment and Interim Progress Reports	Keep to make available on request
108	OENV-Cl.Wt.-2	Clean Water Act, 2006, S. O. 2006, c. 22, s. 54 Enforcement Records	Event = Retain such records as may be prescribed by regulations for period of time prescribed by regulations.
109	OENV-Cl.Wt.-4	Clean Water Act, 2006, S. O. 2006, c. 22, s. 106.(11) Offences — Limitation Period	Event + 2 years (Event = later of: day offence committed or: day evidence first came to attention of risk management official, inspector or under s. 88 inspection)
110	OENV-Cl.Wt.-5	Clean Water Act, 2006, S. O. 2006, c. 22, ss. 8.(1), 12 Terms of Reference	Keep to make available on request
111	OENV-Cl.Wt.-7	Clean Water Act, 2006, S. O. 2006, c. 22, ss. 46.(1),(5),(6),(7) Source Protection Authorities — Annual Progress Reports	Keep to make available on request
112	OENV-Cl.Wt.-8	Clean Water Act, 2006, S. O. 2006, c. 22, s. 62.(9) Seized Record	Event = Shall remove and then return records/data after providing receipt
113	OENV-Ev.As.-5	Environmental Assessment Act, R. S. O. 1990, c. E. 18, s. 26; s. 34; as am. S. O. 2006, c. 36, Sched. C, s. 34.(3) Offences Respecting Records	Not specified Non records–related entry deleted after editorial review.

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
114	OENV-Ev.Pr.-10	Environmental Protection Act, R. S. O. 1990, c. E. 19, s. 195 Environmental Offences Prosecutions — Limitation Period	Event + 2 years (Event = later of: date of offence or: day evidence of offence first came to attention of person appointed under s. 5.)
115	OENV-Ev.Pr.-16	Waste Management — PCBs Regulation, under the Environmental Protection Act, R. R. O. 1990, R. 362, ss. 4.(1),(2),(3),(4),(5) PCB Waste Disposal Records	Event + 2 years (Event = date operator gives written notice to Director that has ceased to be holder of PCB waste)
116	OENV-Ev.Pr.-18	Sewage Systems Regulation, under the Environmental Protection Act, R. R. O. 1990, R. 358, ss. 12.(1),(3),(5),(6)(a) Sewage System Equipment Standards	Not specified Regulation repealed O. R. 244/09, s. 1
117	OENV-Ev.Pr.-19	Sewage Systems Regulation, under the Environmental Protection Act, R. R. O. 1990, R. 358, s. 13.(3) Class 7 Sewage System Daily Records	Event + 1 year (Event = submission of the written report required by clause (c) or for such longer period as the Director notifies the licensee in writing.) Regulation repealed O. R. 244/09, s. 1
118	OENV-Ev.Pr.-252	Records of Site Condition — Part XV.1 of the Act Regulation, under the Environmental Protection Act, O. R. 153/04, ss. 16, 18, 33 Site Condition Reports	Event + 7 years (Event = Record of site condition listing report filed in Registry)
119	OENV-Ev.Pr.-253	Records of Site Condition — Part XV.1 of the Act Regulation, under the Environmental Protection Act, O. R. 153/04, Sched. A Record of Site Condition, Part II, ss. 4-6 Records of Site Condition — Sched. A, Part II, Format	Not specified
120	OENV-Ev.Pr.-254	Records of Site Condition — Part XV.1 of the Act Regulation, under the Environmental Protection Act, O. R. 153/04, Sched. A Record of Site Condition, Part III, ss. 8-12 Records of Site Condition — Sched. A, Part III, Format	Not specified
121	OENV-Ev.Pr.-255	Records of Site Condition — Part XV.1 of the Act Regulation, under the Environmental Protection Act, O. R. 153/04, Sched. A Record of Site Condition, Part IV, ss. 14 to 15, 26, 35 Records of Site Condition — Sched. A, Part IV, Format	Not specified
122	OENV-Ev.Pr.-297	Waste Audits and Waste Reduction Work Plans Regulation, under the Environmental Protection Act, O. R. 102/94, ss. 5.(1), 32, 33 Office Buildings — Waste Audits and Work Plans	Event + 5 years (Event = preparation of audit or work plan)

Number	FileLaw™ Entry Code	Ontario Citations	Retention/Limitation
123	OENV-Ev.Pr.-298	Waste Audits and Waste Reduction Work Plans Regulation, under the Environmental Protection Act, O. R. 102/94, s. 36.(5) Restaurant Owners — Sales Records for Waste Audits and Work Plans	Not specified
124	OENV-Ev.Pr.-330	Environmental Protection Act, R. S. O. 1990, c. E.19, ss. 168.7.(1),(5),(6), 168.3.1.(2); as am. S. O. 2001, c. 17, s. 2.(36); as am. S. O. 2007, c. 7, Sched. 13, s. 8 Consequence of Filing of Records of Site Condition	Not specified
125	OENV-Ev.Pr.-342	Waste Management — PCBs Regulation, under the Environmental Protection Act, R. R. O. 1990, R. 362, s. 5.(2)(a) PCB Waste Records — Exemption	Not specified Non records–related entry deleted after editorial review.
126	OENV-Ev.Pr.-347	Environmental Protection Act, R. S. O. 1990, c. E. 19, s. 118; as am. S. O. 2007, c. 4, ss. 30.(1), 45.(2) Access to Environmental Protection Information	PRIVACY
127	OENV-Ev.Pr.-356	Classification and Exemption of Spills and Reporting of Discharges, under the Environmental Protection Act, O. R. 675/98, ss. 12.(1.1),(2); as en. O. R. 225/07, s. 6 Class X Pollutant Spill Records	Event + 5 years (Event = spill)
128	OENV-SDW-10	Safe Drinking–Water Act, 2002, S. O. 2002, c. 32, s. 121.(2) Administrative Penalties — Limitation Period	Event + 2 years (Event = later of : day contravention or failure occurred; and day evidence first came to attention of Director or provincial officer)
129	OENV-SDW-11	Safe Drinking–Water Act, 2002, S. O. 2002, c. 32, s. 153 Offence Prosecutions — Limitation Period	Event + 2 years (Event = later of : day offence committed; and day evidence first came to attention of a Director or provincial officer)
130	OENV-SDW-2	Safe Drinking–Water Act, 2002, S. O. 2002, c. 32, ss. 7.(2) to (5); as am. S. O. 2007, c. 10, Sched. D, s. 3.(5) Chief Inspector — Drinking–Water Systems Annual Report	Keep to make available on request as soon as Minister receives
131	OENV-SDW-28	Drinking–Water Systems Regulations, under the Safe Drinking–Water Act, 2002, O. R. 170/03, s. 14.(2) Documents — Electronic Format	Not specified
132	OENV-SDW-29	Drinking–Water Systems Regulations, under the Safe Drinking–Water Act, 2002, O. R. 170/03, Schedule 1: Treatment Equipment Municipal: Large Residential Small Residential, s. 1.6.(3) System Owner — Disinfection Equipment Records	Not specified

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
133	OENV-SDW-32	Drinking–Water Systems Regulations, under the Safe Drinking–Water Act, 2002, O. R. 170/03, Schedule 4: Relief from Schedule 1, s. 4.4; as am. O. R. 418/09, s. 13 Schedule 4 Approval Conditions — Written Assessments	Not specified
134	OENV-SDW-33	Drinking–Water Systems Regulations, under the Safe Drinking–Water Act, 2002, O. R. 170/03, Schedule 5: Relief from Schedule 2 Municipal: Large Non–Residential Small Non–Residential Non–Municipal: Year–Round Residential Seasonal Residential Large Non–Residential Small Non–Residential, ss. 5.4.(1),(2) Schedule 5 Approval Conditions — Written Assessments	Not specified
135	OENV-SDW-4	Safe Drinking–Water Act, 2002, S. O. 2002, c. 32, s. 29.(2) Accreditation Body and Minister — Annual and Other Reports	Keep to make available in manner Minister considers appropriate
136	OENV-SDW-47	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, s. 9.(2); ss. 13.(1) par. 1, (2)(a); as am. O. R. 254/05, s. 3; as am. O. R. 401/07, s. 4 Drinking–Water Testing Services — Directions for Sample Procedures	5 years
137	OENV-SDW-48	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, ss. 10.(1)(e),(2); as am. O. R. 416/09, s. 7 Drinking–Water Testing Services — Samples	Event = Shall retain until drinking–water test result been reported
138	OENV-SDW-49	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, s. 12.(2); ss. 13.(1) par. 3, (2)(b); as am. O. R. 254/05, s. 3; as am. O. R. 401/07, s. 4; as am. O. R. 322/08, s. 4; as am. O. R. 416/09, s. 11 Drinking–Water Testing Services — Sample Acceptances	5 years
139	OENV-SDW-50	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, ss. 13.(1) pars. 1, 6, (2)(a); as am. O. R. 254/05, s. 3; as am. O. R. 401/07, s. 4; as am. O. R. 322/08, s. 4 Drinking–Water Testing Services — Submission, Receipt, Handling and Testing of Water Samples Documents	5 years

Number	FileLaw™ Entry Code	Ontario Citations	Retention/Limitation
140	OENV-SDW-51	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, ss. 13.(1) pars. 2, 3; as am. O. R. 254/05, s. 3; as am. O. R. 401/07, s. 4; as am. O. R. 322/08, s. 4 Drinking–Water Testing Services — Drinking–Water Tests Results and Supporting Documents	5 years
141	OENV-SDW-52	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, s. 13.(1) par. 4; as am. O. R. 254/05, s. 3; as am. O. R. 401/07, s. 4; as am. O. R. 322/08, s. 4 Drinking–Water Testing Services — Section 18 Reports, Schedule 16 Reports/ Transmittal Records	5 years
142	OENV-SDW-53	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, ss. 13.(1) par. 4.1, (3); as am. O. R. 254/05, s. 3; as am. O. R. 401/07, s. 4; as am. O. R. 322/08, s. 4 Drinking–Water Testing Services — Schools, Private Schools and Day Nurseries Test Reports	5 years
143	OENV-SDW-54	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, s. 13.(1) par. 4.2; as am. O. R. 254/05, s. 3; as am. O. R. 401/07, s. 4; as am. O. R. 322/08, s. 4 Drinking–Water Testing Services — Schedule 15.1 Test Reports	5 years
144	OENV-SDW-55	Drinking–Water Testing Services Regulations, under the Safe Drinking–Water Act, 2002, O. R. 248/03, s. 13.(1) par. 5; as am. O. R. 254/05, s. 3; as am. O. R. 401/07, s. 4; as am. O. R. 322/08, s. 4 Drinking–Water Testing Services — Staff Training Records	5 years
145	OENV-SDW-58	Non–Residential and Non–Municipal Seasonal Residential Systems that do not Serve Designated Facilities Regulations, under the Safe Drinking–Water Act, 2002, O. R. 252/05, ss. 6.(1)(a),(5) to (7);Schedule 6: Warning Notice of Potential Problems Non–Residential and Non–Municipal Seasonal Residential Systems: Owner of Drinking–Water System — Posting of Tap Warning Notice for Users Regulation Exemption	Not specified Regulation repealed O. R. 321/08, s. 1
146	OENV-SDW-59	Non–Residential and Non–Municipal Seasonal Residential Systems that do not Serve Designated Facilities Regulations, under the Safe Drinking–Water Act, 2002, O. R. 252/05, ss. 6.(1)(b),(8) Non–Residential and Non–Municipal Seasonal Residential Systems: Owner of Drinking–Water System — Tap Warning Notice Exemption Check Records	5 years at location where provincial officer can conveniently view Regulation repealed O. R. 321/08, s. 1

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
147	OENV-SDW-6	Safe Drinking–Water Act, 2002, S. O. 2002, c. 32, s. 65.(3) Director — Drinking–Water Testing Audits	Keep to make available on request
148	OENV-SDW-60	Non–Residential and Non–Municipal Seasonal Residential Systems that do not Serve Designated Facilities Regulations, under the Safe Drinking–Water Act, 2002, O. R. 252/05, s. 11 Non–Residential and Non–Municipal Seasonal Residential Systems: Owner of Drinking–Water System — Test Results, Approvals, Orders, Regulation	Event = Keep available for inspection during office hours at owner's office but record, report or test results do not have to be kept if more than 2 years old Regulation repealed O. R. 321/08, s. 1
149	OENV-SDW-61	Non–Residential and Non–Municipal Seasonal Residential Systems that do not Serve Designated Facilities Regulations, under the Safe Drinking–Water Act, 2002, O. R. 252/05, s. 12.(1) par. 1, ss. 1,(3);Schedule 1: Sampling and Testing — General, ss. 1–1, 1–2, 1–3. 1–5, 1–8, 1–9; Schedule 2: Microbiological Sampling and Testing (Large Municipal Non–Residential Large Non–Municipal Non–Residential), ss. 2–1 to 2–3; Schedule 3: Microbiological Sampling and Testing (Small Municipal Non–Residential Non–Municipal Seasonal Residential Small Non–Municipal Non–Residential), ss. 1–1 to 1–3 Non–Residential and Non–Municipal Seasonal Residential Systems: Owner of Drinking–Water System — Microbiological Sampling, E-Coli, and Coliform Test Records or Reports	5 years Regulation repealed O. R. 321/08, s. 1
150	OENV-SDW-62	Non–Residential and Non–Municipal Seasonal Residential Systems that do not Serve Designated Facilities Regulations, under the Safe Drinking–Water Act, 2002, O. R. 252/05, s. 12.(1) par. 1, ss. ii, (3),(4); Schedule 5: Corrective Action, ss. 5–1 to 5–4 Non–Residential and Non–Municipal Seasonal Residential Systems: Owner of Drinking–Water System — Aeromonas spp., Pseudomonas aeruginosa, Staphylococcus aureus, Clostridium spp. or fecal streptococci (Group D streptococci), E-coli, Coliforms — Test Records or Reports	5 years Regulation repealed O. R. 321/08, s. 1
151	OENV-SDW-7	Safe Drinking–Water Act, 2002, S. O. 2002, c. 32, s. 71.(2) Water Testing Accreditation Bodies — Annual and Other Reports	Keep to make available on request
152	OENV-SDW-8	Safe Drinking–Water Act, 2002, S. O. 2002, c. 32, ss. 81.(2) pars. 10 to 13,(3),(4) Inspectors / Provincial Officers — Seized Records	Event = After giving receipts shall copy and promptly return to person who produced

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
153	OENV-Wt.Rs.-1	Ontario Water Resources Act, R. S. O. 1990, c. O. 40, s. 94; as am. S. O. 2001, c. 9, Sched. G, s. 6.(38) Ontario Water Resources Act Offence Proceedings — Limitation Period	Event + 2 years (Event = later of: date offence committed and date: offence first came to attention of designated person)
154	OENV-Wt.Rs.-25	Ontario Water Resources Act, R. S. O. 1990, c. O.40, ss. 15.(2)(f) to (h),(3),(4) Investigator — Seized and Video Records	Not specified "may record in manner that does not intercept private communications and meets with reasonable expectations or privacy"
155	OENV-Wt.Rs.-29	Ontario Water Resources Act, R. S. O. 1990, c. O.40, ss. 89.2.(1), 89.2.2.(1),(2), 89.3.(5),(7); as am. S. O. 2001, c. 17, s. 5.(12); as am. S. O. 2007, c. 7, Sched. 30, s. 2.(1), 4 Record of Site Conditions — Orders	Not specified
156	OENV-Wt.Rs.-8	Ontario Water Resources Act, R. S. O. 1990, c. O. 40, ss. 53.1.(7)(a), 11; as am. S. O. 1997, c. 30, Sched. B, s. 25 Sewage Works Records	Event + 6 years (Event = date of repeal)
157	OE-TSS-1	Boilers and Pressure Vessels Regulation, under the Technical Standards and Safety Act, 2000, O. R. 220/01, s. 10.(7) Posting of Boiler/Pressure Vessel Inspection Certificate	Not specified
158	OE-TSS-14	Operating Engineers Regulation, under the Technical Standards and Safety Act, 2000, O. R. 219/01, s. 13.(a) Users or Manufacturers of Prime Movers, Compressors or Refrigeration Compressors — Documentation and Safety Testing	Keep to make available on request
159	OF-Corp.-1	Corporations Act, R.S.O. 1990, c. C.38, s. 302 Corporations Accounting Records/Books of Account	Not specified REMOVE
160	OF-In.Tx.-1	Income Tax Act, R. S. O. 1990, c. I.2, s. 48.(3); as am. S. O. 2004, c. 16, s. 3 Income Tax Offences — Limitation Period	8 years
161	OF-In.Tx.-2	Income Tax Act, R. S. O. 1990, c. I.2, s. 39; as am. S. O. 1993, c. 29, s. 2; as am. S. O. 2004, c. 16, s. 3 Income Tax Accounting Records and Books of Account [Incorporation of Federal Tax Act]	Event + 6 years (Event = end of last taxation year to which records and books of account relate)
162	OF-In.Tx.-3	Income Tax Act, R. S. O 1990, c. I.2, s. 8.(18)(a)(c); as am. S. O. 1998, c. 5, s. 3; as am. S. O. 2004, c. 16, s. 3 Income Tax Deductions — Limitation Period	Event = Taxation year after 1984
163	OF-In.Tx.-4	Income Tax Act, R. S. O. 1990, c. I.2, s. 38.(4); as am. S. O. 2004, c. 16, s. 3 Director's Liability for Income Tax — Limitation Period	Event + 2 years (Event = director last ceased to be a director of that corporation.)

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
164	OF-In.Tx.-5 Duplicate entry see OF-In.Tx.-1 #160	Income Tax Act, R. S. O. 1990, c. I.2, s. 48.(3) Income Tax Act Offences Prosecution — Limitation Period	8 years
165	OF-RST-1	Retail Sales Tax Act, R. S. O. 1990, c. R.31, s. 25.(5); as am. S. O. 2006, c. 33, Sched. Z.4, s. 5 Retail Sales Tax Appeals — Limitation Period	Event + 1 year (Event = day of mailing or delivery by personal service of notice of assessment)
166	OF-RST-14	Definitions, Exemptions and Rebates Regulation, under the Retail Sales Tax Act, R. R. O. 1990, R. 1012, ss. 20.(1),(2); as am. O. R. 304/02, s. 2. Rebate Application — Limitation Period	Event + 4 years (Event = payment of tax under s. 2, 4 or 4.2)
167	OF-RST-18	Retail Sales Tax Act, R. S. O. 1990, c. R.31, ss. 15, 15.(1), 32.(1); s. 41; as am S. O. 1994, c. 13, s. 23 Returns and Records	Keep as prescribed by regulations
168	OF-RST-19	Retail Sales Tax Act, R. S. O. 1990, c. R. 31, ss. 2.(11),(12),(15); s. 2.(16.0.0.1); as en. S. O. 2009, c. 34, Sched. R, s. 1.(1) Retail Sales Tax Refund — Limitation Period	Event + 4 years (Event = date of payment of amount) (possible of 6 month extension under certain circumstances)
169	OF-RST-2	Definitions, Exemptions and Rebates Regulation, under the Retail Sales Tax Act, R. R. O. 1990, R. 1012, s. 6.(9); as am. O. R. 449/05, s. 1 Invoices	Not specified
170	OF-RST-20	Retail Sales Tax Act, R. S. O. 1990, c. R.31, s. 17; as am. S. O. 2001, c. 8, s. 231; as am. S. O. 2001, c. 23, s. 193 Access to Retail Sales Tax Records	PRIVACY
171	OF-RST-7	Definitions, Exemptions and Rebates Regulation, under the Retail Sales Tax Act, R. R. O. 1990, R. 1012, s. 1.2.(3) par. 3. Separate Charges Taxable Services Record	Not specified
172	OF-RST-8	Definitions, Exemptions and Rebates Regulation, under the Retail Sales Tax Act, R. R. O. 1990, R. 1012, s. 21 Location/Form of Records	Not specified
173	OF-RST-9	Definitions, Exemptions and Rebates Regulation, under the Retail Sales Tax Act, R. R. O. 1990, R. 1012, s. 22; as am. O. R. 35/91, s. 4 Retail Sales Tax Accounting Records	Event + 6 years (72 months)(Event = start of fiscal year during which records destroyed unless Minister approves earlier, and no outstanding court action)
174	OF-Txn07-1	Taxation Act, 2007, S. O. 2007, c. 11, Sched. A, s. 141 Business in Ontario — Records and Books	Event + 6 years (Event = end of last taxation year to which records and books of account relate/ and prescribed period)

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
175	OF-Txn07-2	Taxation Act, 2007, S. O. 2007, c. 11, Sched. A, s. 162 Access to Taxation Information	PRIVACY
176	OF-Txn07-3	Taxation Act, 2007, S. O. 2007, c. 11, Sched. A, s. 114.(6); as am. S. O. 2008, c. 7, Sched. S, s. 31 Re–assessments — Limitation Period	Event + 3 years (Event = latest of day which is last day for normal reassessment if Corporation Tax Act section applied before January 1, 2009)
177	OF-Txn07-5	Taxation Act, 2007, S. O. 2007, c. 11, Sched. A, s. 150.(4) Offence Prosecutions — Limitation Period	8 years
178	OHC-DIDF-1	Notice to Patients Regulation, under the Drug Interchangeability and Dispensing Fee Act, R.R.O. 1990, Reg. 936, s. Prescription Drug Purchase Records	Event + 2 years (Event = date of receipt of invoice or record)
179	OHC-Diet.-1	General Regulation, under the Dietetics Act, 1991, O.Reg. 593/94, s. 30.18(3); as am. O.Reg. 181/99, s. 1 Dietetic Members — Professional Portfolios	Not specified
180	OHC-Dn.Hy.-1	General Regulation, under the Dental Hygiene Act, 1991, O. R. 218/94, ss. 19.(1),(2); as am. O. R. 607/98, s. 1 Dental Hygiene Professional Portfolio	Not specified
181	OHC-Dn.Tc.-1	General Regulation, under the Dental Technology Act, 1991, O. R. 604/98, ss. 4.(1), 6.(1)(a) Dental Technology Members — Professional Development Profiles	Not specified
182	OHC-DPR-1	Dentistry Regulation, under the Drug and Pharmacies Regulation Act, R.R.O. 1990, Reg. 547, s. 38(b), (c) Dental Drugs — Purchase/Sale Records	Earlier of: Event + 10 years (Event = Date of last entry) Or: Event = 2 years (Event = Death of member)
183	OHC-DPR-10	Medicine Regulation, under the Drug and Pharmacies Regulation Act, R. R. O. 1990, R. 548, s. 37.(b) Prescription Records	Not specified “shall record”
184	OHC-DPR-11	Drug and Pharmacies Regulation Act, R. S. O. 1990, c. H.4, ss. 156.(1),(2); as am. S. O. 1991, Vol. 2, c. 18, s. 47.(16); s. 159.(1) Prescriptions	2 years
185	OHC-DPR-5	Medicine Regulation, under the Drug and Pharmacies Regulation Act, R. R. O. 1990, R. 548, s. 32 Medical Patient Records and Day Book	Earlier of: Event + 6 years (Event = Date of last entry in record) Or: Event = Member ceases to engage in practice of medicine)

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
186	OHC-DPR-2	Drug and Pharmacies Regulation Act, R. S. O. 1990, c. H.4, s. 153; as am. S. O. 2007, c. 10, Sched. L, s. 17 Pharmacy Managers — Drug Purchase/Sale Records	Not specified
187	OHC-DPR-22	Medicine Regulation,, under the Drug and Pharmacies Regulation Act, R. R. O. 1990, R. 548, s. 41 Records Filing System for Drug Purchase/Sale Records	Not specified
188	OHC-DPR-23	General Regulation, under the Drug and Pharmacies Regulation Act, R. R. O. 1990, R. 551, ss. 59, 61; as am. O. R. 172/08, ss. 6, 8; s. 66 Prescription Refill Records	6 years
189	OHC-DPR-3	Medicine Regulation,, under the Drug and Pharmacies Regulation Act, R. R. O. 1990, R. 548, ss. 35, 36, 37.(a) Drug Purchase/Sale Records	Earlier of: 2 years Or: (Event = until he or she ceases to engage in practice of medicine)
190	OHC-HFSO-1	Health Facilities Special Orders Act, R. S. O. 1990, c. H.5, s. 16.(5); as am. S. O. 2002, c. 18, Sched. I, s. 7 Health Facilities Offence Proceedings — Limitation Period	Event = No limitation
191	OHC-Hl.Dc.-5 Duplicate entry see OHC-DPR-5 #185	Medicine Regulation, under the Health Disciplines Act, R.R.O. 1990, Reg. 548, s. 32 Medical Patient Records	(2) A member shall keep the records required under subsection (1) in systematic manner and shall retain each record for a period of six years after the date of the last entry in the record or until the member ceases to engage in the practice of medicine, whichever first occurs.
192	OHC-Hl.In.-1	Health Insurance Act, R. S. O. 1990, c. H.6, s. 37.1; as am. S. O. 1996, c. 1, s. 31; S. O. 2002, c. 18, Schedule I, s. 8.(19); as am. S. O. 2007, c. 10, Sched. G, s. 23 Health Practitioners, Physicians, Facility — Health Insurance Accounts, Health Services Records	Not Specified
193	OHC-Hl.In.-3	Health Insurance Act, R. S. O. 1990, c. H.6, s. 17.(1); as am. S. O. 1996, c. 1, Schedule H, s. 11 Physician/Health Facilities — Insured Service Accounts	Not specified
194	OHC-HPP-1	Health Protection and Promotion Act, R. S. O. 1990, c. H. 7, s. 59 Boards of Health — Accounting Records, Books and Accounts, Annual Statements	Event = Need not keep beyond period prescribed by regulations.
195	OHC-HPP-10	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, s. 38.(3) Physicians and Nurses — Reportable Events / Immunization Reports	Not specified

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
196	OHC-HPP-12	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, s. 46.(3) Board Proceedings Record	Not specified
197	OHC-HPP-13	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, s. 91.1; as am. S. O. 2002, c. 18, Schedule. I, s. 9.(11); as am. S .O. 2006, c. 19, Schedule L, s. 4; as am. S. O. 2009, c. 33, Sched. 18, s. 12.(10); ss. 77.6.(1),(3),(4),(5); as am. S. O. 2009, c. 33, Sched. 18, s. 12.(6); ss. 77.8.(3),(5); as am. S. O. 2007, c. 10, Sched. F, s. 15; as am. S. O. 2009, c. 33, Sched. 18, s. 12.(6) Access to Medical Officer of Health Reports Containing Personal Information	Not specified
198	OHC-HPP-14	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, ss. 95.4, 100.2 Offences Regarding Records	Not specified Non records–related entry deleted after editorial review.
199	OTH-HPP-4	Camps in Unorganized Territory Regulation, under the Health Protection and Promotion Act, R. R. O. 1990, R. 554, s. 11 Camp Operators — Daily Records of Water Treatment	1 year
200	OHC-HPP-18	Communicable Diseases — General Regulation, under the Health Protection and Promotion Act, R. R. O. 1990, R. 557, s. 2; as am. O. R. 420/07, s. 1 Animal Bite Documentation	Not specified
201	OHC-HPP-19	Communicable Diseases — General Regulation, under the Health Protection and Promotion Act, R. R. O. 1990, R. 557, ss. 4.(1),(2)(c), 5.(1) Psittacosis or Ornithosis Documentation	Not specified
202	OHC-HPP-2	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, s. 58, 59.(3) Boards of Health — Minutes of Proceedings / By–laws and Resolutions	Event = Shall keep or cause to be kept but need not keep beyond period of time prescribed by regulations
203	OHC-HPP-20	Control of West Nile Virus Regulation, under the Health Protection and Promotion Act, O. R. 199/03, Table 1, Note, par. 2 Medical Officer of Health — Confirmed Mosquito Control Action Adverse Effect Records	Not specified
204	OHC-HPP-28	Orders Under s. 22.1 Of The Act Regulation, under the Health Protection and Promotion Act, O. R. 166/03, s. 15 Physician's Report Format	Not Specified Regulation repealed O. R. 452/07, s. 1

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
205	OHC-HPP-3	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, ss. 7.(1),(2) Ministry — Mandatory Health Program and Services Guidelines	Not specified
206	OMUN-HPP-1	Public Pools Regulation, under the Health Protection and Promotion Act, R. R. O. 1990, R. 565, ss. 8-9 Daily Pool Records	1 year
207	OHC-HPP-4	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, ss. 11.(2),(3); as am. S. O. 2004, c. 3, Schedule A, s. 86; s. 12.(2); as am. S. O. 2006, c. 19, Sched. L, s. 11.(3) Access to Reports of Investigations	Not specified The medical officer of health shall report the results of the investigation to the complainant, but shall not include in the report personal health information within the meaning of the Personal Health Information Protection Act, 2004 in respect of a person other than the complainant, unless consent to the disclosure is obtained in accordance with that Act
208	OHC-HPP-43	Reports Regulation, under the Health Protection and Promotion Act, R. R. O. 1990, R. 569, s. 5; as am. O. R. 426/07, s. 4 Physicians or Registered Nurses ' Communicable Disease Report Format	Not specified
209	OTH-HPP-6	Public Spas Regulation, under the Health Protection and Promotion Act, O. R. 428/05, ss. 2.(3), 9.(2), 13.(2),(3), 14.(2), 18.(1), 19.(2) Public Spas — Posting of Public Notices	Not specified
210	OTH-HPP-9	Public Spas Regulation, under the Health Protection and Promotion Act, O. R. 428/05, s. 22.(2) Public Spa Operators — Inspection Records	1 year
211	OHC-HPP-6	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, ss. 27, 32; ss. 29.(1),(2), 30; as am. 2007, c. 10, Sched. F, ss. 5, 7 Administrators of Hospitals / Lab Operators / Medical Officers of Health / Physicians or Registered Nurses — Reportable Disease Records and Reports	Not specified
212	OHC-HPP-7 Duplicate entry see OHC-HPP-6 #211	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, s. 30 Medical Death Certificates and Disease Reports	Not Specified

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
213	OHC-HPP-8	Health Protection and Promotion Act, R. S. O. 1990, c. H.7, s. 28; ss. 29.1, 34; as am. S. O. 2007, c. 10, Sched. F, ss. 6, 8.(1) Principals / Medical Officers of Health / Physicians and Registered Nurses — Communicable Disease Reports	Not specified
214	OHC-ISP-1	Immunization of School Pupils Act, R. S. O. 1990, c. I.1, ss. 11, 14.(2) School Pupil Immunization Records	Not specified
215	OHC-ISP-2	General Regulation, under the Immunization of School Pupils Act, R. R. O. 1990, R. 645, s. 1; as am. O. R. 299/96, s. 1 Medical Officers of Health — School Pupil Immunization Records	Not specified
216	OHC-MBT-1	General Regulations, under the Mandatory Blood Testing Act, 2006, O. R. 449/07, s. 15.(1)(i) Physician — Completed Laboratory Requisitions	Not specified
217	OHC-MBT-2	General Regulations, under the Mandatory Blood Testing Act, 2006, O. R. 449/07, s. 8.(1)(b) Medical Officer of Health — Access to Applicant Information	Not specified
218	OHC-Nrsing-1	General Regulation, under the Nursing Act, 1991, O. R. 275/94, ss. 22.(b), 25; as am. O. R. 39/98, s. 11 Nursing College Member Records	Not specified 25.(1) Every member shall, (a) maintain records relating to the member's ongoing education, practice, professional development and reflective practice, in accordance with the standards of practice published by the College and provided to each member;
219	OHC-ODB-2	General Regulation, under the Ontario Drug Benefit Act, O. R. 201/96, s. 29.(1), Table, Col. 1, row 1; s. 29.(2); as am. O. R. 459/06, s. 28 Physician/Pharmacy Transaction Statements	Event + 2 years (Event = day on which daily statement is prepared)
220	OHC-ODB-6	General Regulation, under the Ontario Drug Benefit Act, O. R. 201/96, s. 29.(1), Table, Col. 1, row 5; s. 29.(2); as am. O. R. 459/06, s. 28 Prescriptions/Adverse Drug Reaction Forms	Event + 2 years (Event = date on which form received)
221	OHC-OHS-1	Health Care and Residential Facilities Regulations, under the Occupational Health and Safety Act, O. R. 67/93, s. 4; s. 5; as am. O.R. 25/09, s. 2 5 Employers — Accident Records	1 year (or longer to ensure 2 more recent records/reports on file)

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
222	OHC-OHS-15	Health Care and Residential Facilities Regulation, under the Occupational Health and Safety Act, O. R. 67/93, ss. 96, 116 Employers — Written Measures and Procedures for Antineoplastic Agents and Other Hazardous Infectious Agents	Not specified
223	OHC-OHS-8	Health Care and Residential Facilities Regulation, under the Occupational Health and Safety Act, O. R. 67/93, ss. 8-9 Employers — Health Measures Procedures	Not specified
224	OHC-PHIPA-1	Personal Health Information Protection Act, 2004, S. O. 2004, c. 3, Sched. A, s. 10 Health Information Custodians — Information Practices	Not specified
225	OHC-PHIPA-12	Personal Health Information Protection Act, 2004, S. O. 2004, c. 3, Sched. A, s. 16 Health Information Custodians — Statement and Notification on Information Practices	Not specified
226	OHC-PHIPA-2	Personal Health Information Protection Act, 2004, S. O. 2004, c. 3, Sched. A, s. 9.(1) Privacy Application Period Where Individual Deceased	Event + 50 years (Event = death of individual) (no longer private) Event + 100 years (Event = record created) (no longer private)
227	OHC-PHIPA-4	Personal Health Information Protection Act, 2004, S. O. 2004, c. 3, Sched. A, s. 4.(1); as am. S. O. 2007, c. 10, Sched. H, s. 2 Personal Health Information	Not specified Non records–related entry deleted after editorial review.
228	OHC-PHIPA-5	Personal Health Information Protection Act, 2004, S. O. 2004, c. 3, Sched. A, s. 6 Access to Information of Health Information Custodians	Not specified
229	OHC-PHIPA-8	Personal Health Information Protection Act, 2004, S. O. 2004, c. 3, Sched. A, s. 13.(1) Personal Health Information Custodians — Method of Records Disposal	Event = Dispose of in accordance with prescribed requirements, if any
230	OHC-PHIPA-9	Personal Health Information Protection Act, 2004, S. O. 2004, c. 3, Sched. A, s. 13.(2) Personal Health Information Custodians — Records Retention	Event = Retain for as long as necessary to allow the individual to exhaust any recourse under this Act
231	OHC-SFO-1	Smoke–Free Ontario Act, S. O. 1994, c. 10, ss. 6, 9.(3)(c),(6)(c), 10, 18.(1),(2),(5) Posting of Temporary Prohibition Signs, No Smoking and Health Warning Signs	Not specified
232	OHC-SFO-2	Smoke–Free Ontario Act, S. O. 1994, c. 10, s. 14.(14) Seized Records	Event = Shall be returned to person within reasonable time

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
233	OHC-SFO-3	General Regulation, under the Smoke–Free Ontario Act, O. R. 48/06, s. 2, 10, 11.(1),(2), 15.(1),(2), 17.(1),(2), 18.(3) to (5), 22.(1)(2), 25.(2),(3) Posting of Signs	Not specified
234	OHR-Em.St2000-10	Employment Standards Act, 2000, S. O. 2000, c. 41, s. 139 Employment Standards Act, 2000 Prosecution — Limitation Period	2 years
235	OHR-Em.St2000-11	Employment Standards Act, 2000, S. O. 2000, c. 41, ss. 15.1.(1),(4),(5); as am. S. O. 2002, c. 18, Sched. J, s. 3.(9) Employers — Vacation Records	3 years
236	OHR-Em.St2000-2	Employment Standards Act, 2000, S. O. 2000, c. 41, ss. 15.(1) par. 1, 15.(5) par. 1; s. 16; as am. S. O. 2004, c. 21, s. 3 Employers — Employee Name and Address Records	Event + 3 years (Event = date employee ceased to be employed by employer)
237	OHR-Em.St2000-22	Employment Standards Act, 2000, S. O. 2000, c. 41, ss. 15.(8), 16; as am. S. O. 2004, c. 21, s. 2, 3 Excess Work Hours Employer Employee Agreements	Event + 3 years (Event = last day on which work performed under agreement)
238	OHR-Em.St2000-24	Terms and Conditions of Employment in Defined Industries, under the Employment Standards Act, 2000, O. R. 291/01, s. 8, par. 6 Posting of Work Schedules	Not specified Deleted after editorial review.
239	OHR-Em.St2000-26	Employment Standards Act, 2000, S. O. 2000, c. 41, ss. 15.1.(2),(3),(5), 41.1.(1),(4); as am. S. O. 2002, c. 18, Schedule J, ss. 3.(9),(21) Vacation Stubs / Record	3 years
240	OHR-Em.St2000-3	Employment Standards Act, 2000, S. O. 2000, c. 41, ss. 15.(1) par. 2, 15.(5) par. 2; s. 16; as am. S. O. 2004, c. 21, s. 3 Employers — Employee Records / Date of Birth	Event + 3 years (Event = earliest of: employee's 18th birthday or date employee ceased to be employed by employer)
241	OHR-Em.St2000-4	EEmployment Standards Act, 2000, S.O. 2000, c. 41, ss. 15.(1) par. 3, 15.(5) par. 1; s. 16; as am. S. O. 2004, c. 21, s. 3 Employers — Employment Records / Date Employment Started	Event + 3 years (Event = date employee ceased to be employed by employer)
242	OHR-Em.St2000-5	Employment Standards Act, 2000, S. O. 2000, c. 41, ss. 15.(1) par. 4,(3),(5) par. 3; s. 16; as am. S. O. 2004, c. 21, s. 3 Employers — Employee Number of Hours Worked Records	Event + 3 years (Event = date (day or week) to which information relates)

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
243	OHR-Em.St2000-6	Employment Standards Act, 2000, S. O. 2000, c. 41, ss. 15.1 par. 5; s. 15.5 par. 4; s. 16; as am. S. O. 2004, c. 21, s. 3 Employers — Wage Statements and Termination Pay Records	Event + 3 years (Event = information given to employee)
244	OHR-Em.St2000-8	Employment Standards Act, 2000, S. O. 2000, c. 41, s. 15.(7); as am. S. O. 2006, c. 13, s. 3.(1); as am. S. O. 2007, c. 16, Sched. A, s. 2; s. 16; as am. S. O. 2004, c. 21, s. 3; as am. S. O. 2009, c. 16, s. 1 Employers — Leave Notices, Certificates, Correspondence and Documents	Event + 3 years (Event = day leave expired.)
245	OHR-FIPP-1	Freedom of Information and Protection of Privacy Act, R. S. O. 1990, c. F.31, ss. 40.(1),(2),(3) Personal Information Records — Retention of Personal Information Records	Event = Retain for period prescribed by regulation so that individual to whom relates has reasonable opportunity for access
246	OHR-FIPP-3	Freedom of Information and Protection of Privacy Act, R. S. O. 1990, c. F.31, s. 40.(4) Disposal of Personal Information	Event = Dispose of in accordance with the regulations
247	OHR-WSI-8	Workplace Safety and Insurance Act, 1997, S. O. 1997, c. 16, Schedule A, s. 157.1.(1); as am. S. O. 2001, c. 9, Schedule I, s. 4.(5) Offence Prosecutions — Limitation Period	Event + 2 years (Event = most recent act or omission upon which prosecution is based comes to knowledge of Board)
248	OHR-WSI-1	Workplace Safety and Insurance Act, 1997, S. O. 1997, c. 16, Schedule A, s. 80; as am. S. O. 2001, Schedule I, s. 4.(2) Schedule 1 Employers — Wages Record	Not specified
249	OHR-WSI-10	First Aid Requirements Regulations, under the Workplace Safety and Insurance Act, 1997, R. R. O. 1990, R. 1101, s. 5 Accident and First Aid Records	Not specified
250	OHR-WSI-2	Workplace Safety and Insurance Act, 1997, S. O. 1997, c. 16, Schedule A, s. 22.(1),(3) Accident Claims — Limitation Period	Event + 6 months (Event = accident or when worker learns he/she suffers from disease)
251	OS-Fir.PP-73	Fire Protection and Prevention Act, 1997, S. O. 1997, c. 4, s. 9.(2)(f) Reported Fire Records	Not specified
252	OLA-Limi02-1	Limitations Act, 2002, S. O. 2002, c. 24, Schedule B, s. 4 General Limitation Period	2 years

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
253	OLA-Pn.Bn.-1	Pension Benefits Act, R.S.O. 1990, c. P.8, s. 110(6); as am. S.O. 1997, c. 28, s. 220(2) Pension Benefits Offence Prosecutions — Limitation Period	No prosecution for an offence under this Act shall be commenced after five years after the date when the offence occurred or is alleged to have occurred.
254	OMUN-MFIPP-1	General Regulation, under the Municipal Freedom of Information and Protection of Privacy Act, R. R. O. 1990, R. 823, s. 5 Personal Information Retained by Institutions	1 year or shorter “as set out in by–law or resolution made by the institution. . .or on consent”
255	OMUN-MFIPP-40	Municipal Freedom of Information and Protection of Privacy Act, R. S. O. 1990, c. M. 56, s. 34.(1) Personal Information Bank Index	Keep to make available on request
256	OMUN-MFIPP-43	Municipal Freedom of Information and Protection of Privacy Act, R. S. O. 1990, c. M. 56, s. 36.(2) General Right of Correction — Limitation Period	Event + 1 year (Event = time correction requested or statement of disagreement required)
257	OMUN-MFIPP-46	Municipal Freedom of Information and Protection of Privacy Act, R. S. O. 1990, c. M. 56, s. 39.(2) Appeals — Limitation Period	Event + 30 days (Event = day notice given of decision)
258	OPM-FIPP-2	General Regulation, under the Freedom of Information and Protection of Privacy Act, R. R. O. 1990, R. 460, s. 10.(1), pars. 1, 3, 4, 5, 7 Personal Information used for Research Purposes	Event = Destroy all individual identifiers by date specified in agreement
259	OPM-FIPP-3	Disposal of Personal Information Regulation, under the Freedom of Information and Protection of Privacy Act, R. R. O. 1990, R. 459, s. 6 Institution Heads — Personal Information Disposal Records	Not specified
260	OPM-FIPP-5	Freedom of Information and Protection of Privacy Act, R. S. O. 1990, c. F. 31, s. 2.(2) Personal Information of Deceased Individuals	Event + 30 years (Event = death; no longer private)
261	OS-Fir.PP-31	Fire Code, under the Fire Protection and Prevention Act, 1997, O. R. 213/07, Division B, Part II, s. 2.8.2.1, Division C, s. 1.3.2.5.(3) Fire Safety Plans	Not specified “shall be kept in building in an approved location”
262	OS-Fir.PP-33	Fire Code, under the Fire Protection and Prevention Act, 1997, O. R. 213/07, Division B, Part II, s. 2.8.3.2.(3) Fire Drill Records	Event + 1 year (12 months)(Event = fire drill)
263	OS-Fir.PP-55	Fire Code, under the Fire Protection and Prevention Act, 1997, O. R. 213/07, Division B, Part VI, s. 6.2.7.5 Portable Extinguisher — Maintenance Records	Not specified

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
264	OS-Fir.PP-57	Fire Code, under the Fire Protection and Prevention Act, 1997, O. R. 213/07, Division B, Part VI, s. 6.3.2.2.(4), Division A, s. 1.1.2.1 Tests Records of Devices, Components and Circuits of Fire Alarm Systems	Event + 2 years (Event = Report prepared; as long as current and immediately preceding report are available; retained at building premises for examination on request)
265	OS-Fir.PP-58	Fire Code, under the Fire Protection and Prevention Act, 1997, O. R. 213/07, Division B, Part VI, s. 6.3.2.2.(5), Division A, s. 1.1.2.1 Test Records of Fire Alarm Monitoring Signals	Event + 2 years (Event = Report prepared; as long as current and immediately preceding report are available; retained at building premises for examination on request)
266	OS-Fir.PP-61	Fire Code, under the Fire Protection and Prevention Act, 1997, O. R. 213/07, Division B, Part VI, ss. 6.5.1.8.(1),(2) Sprinkler Systems Inspections Records	Not specified
267	OHC-OHS-1	Health Care and Residential Facilities Regulations, under the Occupational Health and Safety Act, O. R. 67/93, s. 4; s. 5; as am. O.R. 25/09, s. 2 5 Employers — Accident Records	1 year (or longer to ensure 2 more recent reports/records on file)
268	OS-OHS-10	Designated Substance — Asbestos Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 837, s. 12 Employers — Airborne Asbestos Concentration Monitoring Records	5 years
269	OS-OHS-13	Designated Substance — Benzene Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 839, s. 12 Employers — Airborne Benzene Monitoring Records	5 years
270	OS-OHS-15	Designated Substance — Ethylene Oxide Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 841, s. 13 Employers — Airborne Ethylene Oxide Monitoring Records	5 years
271	OS-OHS-18	Designated Substance — Isocyanates Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 842, s. 13 Employers — Airborne Isocyanates Monitoring Records	5 years
272	OS-OHS-21	Designated Substance — Lead Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 843, s. 12 Employers — Airborne Lead Monitoring Records	5 years

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
273	OS-OHS-24	Designated Substance — Mercury Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 844, s. 12 Employers — Airborne Mercury Monitoring Records	5 years
274	OS-OHS-27	Designated Substance — Silica Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 845, s. 12 Employers — Airborne Silica Monitoring Records	5 years
275	OS-OHS-30	Designated Substance — Vinyl Chloride Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 846, s. 12 Employers — Airborne Vinyl Chloride Monitoring Records	5 years
276	OS-OHS-32	Designated Substance — Asbestos Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 837, ss. 7, 8 Employers — Asbestos Control Program Measures and Procedures Records	Not specified
277	OS-OHS-36	Occupational Health and Safety Act, R. S. O. 1990, c. O.1, ss. 26.(1)(c),(d),(f) Employers — Biological/Chemical/Physical Agents Handling/Exposure Records	Not specified
278	OS-OHS-40	Designated Substance — Coke Oven Emissions Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 840, s. 12 Employers — Coke Oven Emissions Monitoring / Control Program Records	5 years
279	OS-OHS-43	Designated Substance — Ethylene Oxide Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 841, ss. 7.(1),(2)(c) Employers — Ethylene Oxide Measures and Procedures Exposure Records / Ethylene Oxide Control Program Records	Not specified
280	OS-OHS-48	Occupational Health and Safety Act, R. S. O. 1990, c. O.1, s. 69 Health and Occupational Safety Prosecutions — Limitation Period	Event + 1 year (Event = last act or default)
281	OS-OHS-5	Designated Substance — Acrylonitrile Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 835, s. 12 Employers — Airborne Acrylonitrile Concentrations Monitoring Records	5 years

Number	FileLaw™Entry Code	Ontario Citations	Retention/Limitation
282	OS-OHS-52	Designated Substance — Isocyanates Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 842, ss. 8(1),(2)(c),(d),(f) Employers — Isocyanates Exposure Measures and Procedures Records / Isocyanates Control Program Records	Not specified
283	OS-OHS-53	Occupational Health and Safety Act, R. S. O. 1990, c. O.1, s. 9.(22) Joint Health & Safety Committee — Minutes of Proceedings	Not specified
284	OS-OHS-54	Designated Substance — Lead Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 843, ss. 7.(1),(2)(c),(e) Employers — Lead Control Program / Lead Exposure Measures and Procedures Records	Not specified
285	OS-OHS-7	Designated Substance — Arsenic Regulations, under the Occupational Health and Safety Act, R. R. O. 1990, R. 836, s. 12 Employers — Airborne Arsenic Concentrations Monitoring Records	5 years
286	OSS-CFS-28	Child and Family Services Act, R. S. O. 1990, c. C.11, s. 54 Child/Family Services — Assessment Reports	Not specified
287	OSS-CFS-37	General Regulation, under the Child and Family Services Act, R. R. O. 1990, R. 70, ss. 111.(7),(8),(9); as am. O. R. 493/06, s. 17.(4) Social History of Child	Not specified
288	OSS-CFS-4	Register Regulation, under the Child and Family Services Act, R. R. O. 1990, R. 71, ss. 4.(3),(6) Child Medical/Dental Examination Records	Not specified
289	OS-Sm.Wp.-1	Smoking in the Workplace Act, R.S.O. 1990, c. S.13, s. 4 Smoking in the Workplace	Not specified Act is repealed by S. O. 2005, c. 18, s. 16
290	OTH-HPP-1	Recreational Camps Regulation, under the Health Protection and Promotion Act, R.R.O. 1990, Reg. 568, s. 28 Posting of Food Processing Equipment Instructions	Not specified
291	OLA-Limi02-7	Limitations Act, 2002, S. O. 2002, c. 24, Schedule B, ss. 15.(1),(2) Ultimate Limitation Period	Event + 15 years (Event = act or omission took place)

APPENDIX D: EMAIL

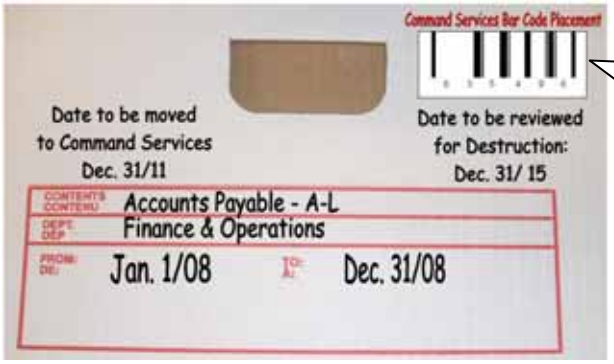
Development pending.

MIDDLESEX-LONDON HEALTH UNIT

Records Management Program
Retention Schedule

Tips for Packing Boxes for Health Unit Records Room and Off-site Record Storage

1. Use only boxes that measure approximately 15 ¼" L x 12 ½" W x 10" H (38.7 cm x 31.8 cm x 25.4 cm) with an attached lid.
2. Open the box, so that the lid opens to the right
3. Ensure the box is properly labelled:
   - Print the required information using a marker so that it is easily seen as depicted below.
   - With the lid opening to the right, provide the following information on the end of the box facing you:
     - type of record, i.e. contents
     - Service Area
     - date range for the records
     - date to be moved to off-site storage – put on the Left Side
     - date to be reviewed for disposal – put on the Right Side
   - Please do not use abbreviations and write the date as shown in the example, ie. month, day, year
   - Ensure that when placing the box on the shelf that the above information is visible.



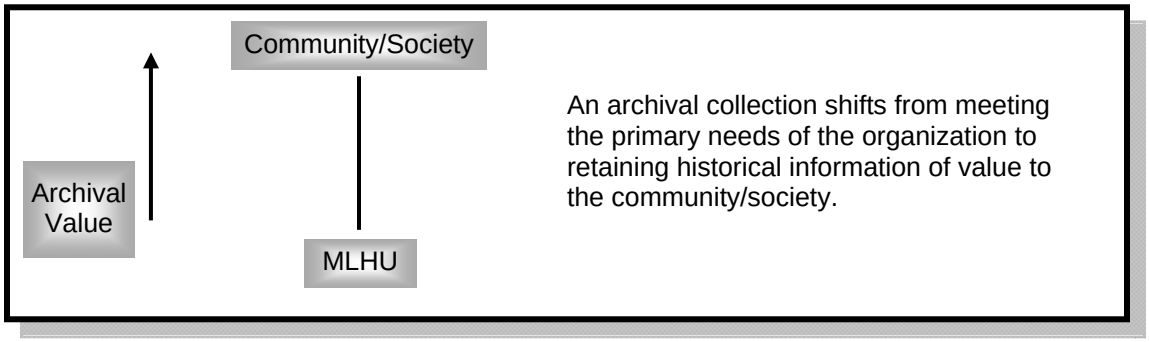
Prior to being sent to Command Services – the bar code label is to be placed in the upper right corner as shown

4. Remove documents from binders (binders require a lot of space, and the lid often does not close)
5. Avoid hanging folders as they require more space than other file folders.
6. Use an additional file folder when the original folder gets too full and label, i.e. Volume 1, Volume 2, etc. The normal capacity of a file folder is ¾".
7. Box records in order e.g. alphabetically or by date with the latest date up front.
8. Box the same types of records together i.e. do not mix one type of record with another.
9. Try to pack so the boxes are full, yet allow sufficient room so can easily access files.
10. Do not over pack – the box should easily close without the sides bulging.
11. Do not use post-its for labelling.
12. Use elastics sparingly if the record is to be retained for a long time – elastics disintegrate – consider using file folders or clips.
13. Avoid storing records in envelopes within a box, unless the documents are confidential.
14. If the document is confidential e.g. In Camera Board of Health Minutes, place in envelope, label "Confidential", seal, place tape over the seal, date and sign your name.

Only <u>records</u> should be stored in the Health Unit Records Room and in Off-Site Records Storage

APPENDIX F: CRITERIA TO DETERMINE ARCHIVAL VALUE

A: PURPOSE OF AN ARCHIVAL COLLECTION



Typically, an archival collection represents a small number of the organization's records, e.g. 2-5%.

B: CRITERIA TO ASSIST IN IDENTIFYING RECORDS HAVING ARCHIVAL VALUE.

Is the record:

- Unique? Or available elsewhere?
- In good physical condition?
- Accessible in the way presented?, e.g. if on "floppy diskettes" do you have the capability to read and make available to others?

The record should offer information that is of permanent enduring value.

C: OTHER CONSIDERATIONS

- Does MLHU have the legal authority to hold the record?
- If the volume of records is too high, consider taking a smaller representative sample to provide a snapshot of what the records are about.
- The collection should contain MLHU records that are of community/societal value and do not usually include personal collections.

D: STORAGE OF ARCHIVAL RECORDS

- Ideal temperature: 18-22ºC, i.e. if lower, the paper can become brittle and deteriorate when touched; if higher the moisture increases and the potential for mould exists.
- Ideal humidity: 40-45%; if above 45% the potential for mould exists and if less than 40% the paper becomes brittle. A humidifier or dehumidifier will assist in controlling humidity.
- Light is also damaging to archival materials as it can cause paper to fade and yellow when the light interacts with chemicals in the paper.

- Acid free file folders, acid free boxes or Hollinger boxes are recommended for archival material.
- Mylar sleeves or acid free envelopes are recommended for photographs and slides, provided humidity and temperature are controlled.
- Store photographs upright; glass to glass; do not store in "regular" plastic (bubble wrap may be used).
- Store like records together; i.e. Board minutes together, newsletters together, photographs together, etc.

E: ARCHIVES ONTARIO

Archives Ontario provides The Archives Advisor Programme. The Programme offers consultations, response to queries by email, regular mail, telephone or fax regarding archival services and specialized advice, and onsite visits at no charge to organizations.

Email: archivesadvisor@rogers.com.

F: ARCHIVAL RECORDS INCLUDING CONFIDENTIAL IDENTIFYING INFORMATION

Records of historical significance that may contain confidential, identifying information will not generally be accessible without prior approval of the Medical Officer of Health. Typically such records are closed for a period of time, e.g. 20 years and are usually only accessed by researchers and will require a research agreement.

2011 04 04

MIDDLESEX-LONDON HEALTH UNIT

Appendix G
Policy 6-030

DECISION PATH AND REQUIRED AUTHORIZATION FOR RECORD DISPOSAL

GUIDING PRINCIPLES

- Applies to paper and electronic records.
- Retention periods are based on : 1) the "current" year e.g. C+ 2; an "event" (E) such as the date of the client's last visit, resolution of a complaint e.g. E +2; or after a record is considered "Superseded/ Obsolete" (S/O) e.g. S/O + 2.
- **Triggers for Action**: to facilitate use and consistent application of the retention periods, records should be reviewed at the beginning of the calendar year to determine which records:
    - have met their active, inactive and total retention periods
    - need to be moved to the Health Unit Records Room, sent to off-site storage, purged or retained for archival value.
- The Service/Program who is the "Record Steward" and responsible for the "official record" is expected to apply the retention periods. Copies held by others may be destroyed before the required retention period.
- Two levels of authorization are required before official records can be purged.
- **Methods of disposal:**
    - Paper records containing confidential , personal or personal health information must be placed in the locked gray bins for "onsite " shredding by a certified contractor; other records may be placed in the blue recycling bins. **When in doubt, treat the document as confidential.**
    - Electronic records are to be deleted from all directories, ensuring that all versions e.g. duplicates, drafts are deleted from all folders, disks, laptops and other portable computing devices.
    - CD's, diskettes, audio & video media are to be placed in a special locked bin provided by the certified contractor. The bin will be located in Information Technology.

* see Appendix A for definitions and examples

Decision Path

The Manager, Special Projects (Records Management & Accreditation) is available to provide guidance and assistance

I. Staff Member Records*	II. Team/Program/Service Records*	III. Records Held in the Health Unit Records Room	IV. Records Held in Off-Site Storage
▪ All staff are responsible for applying the CS/RS to their records. ▪ According to the CS/RS certain records are to be reviewed for archival value (AR) before they are destroyed. ▪ Transitory* records are to be destroyed/deleted when they have fulfilled their purpose provided no FOI request or legal action. ▪ Staff who hold official records that are not captured under II must complete Form 01 (paper) or Form 02 (electronic) before official records can be destroyed (see attached forms). * electronic and paper records	▪ Administrative staff will work with team/service members & responsible Manager(s) on an annual basis to manage team/ program/service records. ▪ Managers, in consultation with their administrative staff will decide when records should be sent to the Health Unit Records Room or to off-site storage. ▪ If official* records are scheduled to be destroyed according to the CS/RS, the administrative staff under the direction of the Manager will initiate the process using *Authorization & Documentation of Destruction for All Paper Records* (see Form 01) or *Authorization & Documentation of Destruction for all Electronic Records* (See Form 02 attached). ▪ The Manager is responsible for ensuring that there are no FOI requests or legal action and for assessing the records for archival value. ▪ Administrative staff will document when the destruction/ deletion is completed. * electronic and paper records	▪ There will be 1 standard database used by all Service Areas to track Service Area records stored in the Health Unit Records Room. The database will include date sent, title of the series, date range and date to be reviewed for destruction, responsible team/ Manager, final status. Service Areas will have access <u>only</u> to their record listing. ▪ The Manager, Special Projects (Records Management & Accreditation) will have access to the database. ▪ Managers will decide when the records they are responsible for should be sent off-site. ▪ Team/service point person(s) will advise Manager(s) of records that are approaching their retention period or are ready to be moved to off-site storage. ▪ At the <u>beginning of the year</u> for records that met their retention periods at the end of the previous year, the Manager will determine if there are any reasons to retain records beyond their required retention period e.g. FOI requests, legal action or archival value. ▪ Provided there is no reason to retain the record beyond the required retention period, administrative staff will initiate the process for record disposal by using *Authorization & Documentation of Destruction for all Paper Records* (See Form 01 – attached).	▪ Administrative staff with access to Command Services on-line data entry system i.e. www.infokeeper.com will: 1. monitor Service Area holdings stored off-site and 2. at the end of the year will advise Manager(s) of records that are at the end of their retention period. ▪ At the <u>beginning of the year</u> following the year in which the retention period was met, the Manager will determine if there are any reasons to retain records beyond their required retention period e.g. FOI requests, legal action or archival value. ▪ Provided there is no reason to retain the record beyond the required retention period, administrative staff will initiate the process for record disposal by using *Authorization for Administrative Staff to Notify Command Services to Destroy Records* (See Form 03 attached).

Please Note:
If a Director is the official Records Steward, Form 04 (attached) – Authorization for Destruction of Official Records Held by Directors will be used.

* see Appendix A for definitions and examples

CS/RS – Classification System / Retention Schedule

MIDDLESEX-LONDON HEALTH UNIT

Form 01

Authorization & Documentation of Destruction for all Paper Records

☐ Official Team/Program/Service Paper Records

☐ Official Paper Records – held by Staff Member Not Captured in Team/Program/Service Records

☐ Records Stored in the Health Unit Records Room

To be sent to the Manager, Special Projects (Records Management & Accreditation) when destruction complete

Service Area _____

Part A: to be completed by the Staff Member and forwarded to immediate Manager*.

The following official record(s) have met the required retention periods and are to be destroyed. The record(s) are not subject to a Freedom of Information request or legal action and do not meet archival criteria i.e. permanent/enduring value.

Classification Code	Title/Description	Date Range From/To	Required Method of Destruction Confidential Shredding OR Recycling

Date: _____ **Staff Member:** _____
Please type or print

Part B: to be completed by Manager◈ and returned to the Staff Member

☐ The above records are to be destroyed.

☐ **The above records are not to be destroyed. Please list exceptions and include justification:**

_____

Date: _____ **Manager*:** _____
Please type or print

Part C: To be completed by Staff Member

The destruction of all of the above records according to the specified method of destruction was completed on:
Date: _____

Exceptions: _____

Comments: _____

Date: _____ **Responsible Staff Member:** _____
Please type or print

Ext.: _____ **Title:** _____

* if no Manager, role assumed by Director

MIDDLESEX-LONDON HEALTH UNIT

Form 02

Authorization & Documentation of Destruction for all Electronic* Records

☐ Official Team/Program/Service Electronic Records

☐ Official Electronic Records – held by Staff Member Not Captured in Team/Program/Service Records

To be sent to the Manager, Special Projects (Records Management & Accreditation) when destruction complete

Service Area _____

Part A: to be completed by the Staff Member and forwarded to immediate Manager**.

The following official record(s) have met the required retention periods and are to be destroyed. The record(s) are not subject to a Freedom of Information request or legal action and do not meet archival criteria i.e. permanent/enduring value.

Classification Code	Title/Description	Date Range From/To

Date: _____ **Staff Member:** _____
Please type or print

Part B: to be completed by Manager** and returned to the Staff Member

☐ The above records are to be destroyed.

☐ **The above records are not to be destroyed. Please list exceptions and include justification:**

_____

Date: _____ **Manager**:** _____
Please type or print

Part C: To be completed by Staff Member

Deletion of all of the above records was completed on: _____
Date

Exceptions: _____

Comments: _____

Date: _____ **Responsible Staff Member:** _____
Please type or print

Ext.: _____ **Title:** _____

* staff folders, shared team/program/Service Area folders on all network drives and USB keys.
** if no Manager, role assumed by Director

MIDDLESEX-LONDON HEALTH UNIT

Form 03

Authorization for Administrative Staff To Notify Command Services to Destroy Records

To be sent to the Manager, Special Projects (Records Management & Accreditation) when destruction complete

Service Area _____

Part A: to be completed by Administrative Staff and forwarded to the Manager*

The following official record(s) have met the required retention periods and are to be destroyed. The record(s) are not subject to a Freedom of Information request or legal action and do not meet archival criteria i.e. permanent/enduring value.

Box Number	Title/Description	Date Range From/To

Date: _____ **Staff Member:** _____
Please type or print

☐ **Reviewed by Manager*:** _____ **Ext.** _____
Please type or print

Part B: to be completed by Director & returned to the Manager

☐ The above records are to be destroyed.

☐ **The above records are not to be destroyed. Please list exceptions and include justification:**

_____

Date: _____ **Director:** _____
Please type or print

Part C: To be completed by Administrative Staff

Command Services was notified to destroy the record(s) on: _____
Specify Date

Command Services notified MLHU that the records had been destroyed on: _____
Specify Date

Comments: _____

Date: _____ **Administrative Staff:** _____
Please type or print

Ext.: _____ **Title:** _____

* if no Manager, role assumed by Director

MIDDLESEX-LONDON HEALTH UNIT

Form 04

Authorization for Destruction of Official Records Held by Directors

To be sent to the Manager, Special Projects (Records Management & Accreditation) when destruction complete

Service Area _____

Part A: to be completed by Administrative Staff and reviewed by the Director.

The following official record(s) have met the required retention periods and are to be destroyed. The record(s) are not subject to a Freedom of Information request or legal action and do not meet archival criteria i.e. permanent/enduring value.

Classification Code/ Box Number	Title/Description	Date Range From/To

Date: _____ **Director:** _____
Please type or print

Part B: to be completed by Medical Officer of Health (MOH) & returned to the Director

☐ The above records are to be destroyed.

☐ **The above records are not to be destroyed. Please list exceptions and include justification:**

_____

Date: _____ **MOH:** _____
Please type or print

Part C: To be completed by Administrative Staff

The destruction of on-site records according to the specified method of destruction* was completed on:

Date: _____

Command Services was notified to destroy the record(s) on: _____
Specify Date

Command Services notified MLHU that the records had been destroyed on: _____
Specify Date

Comments: _____

Date: _____ **Administrative Staff:** _____
Please type or print

Ext.: _____ **Title:** _____

* **Method of Destruction On-Site Records:** Records containing confidential, personal or personal health information must be placed in locked gray bins for "on-site" shredding; other records to be placed in blue recycling bins; electronic records to be deleted from all directories, ensuring that all versions are deleted from all folders, disks, laptops and other portable computing devices, CD's, floppy diskettes, audio & video media to be placed in specially designated locked bins for confidential destruction.

RECORDS & INFORMATION MANAGEMENT PROGRAM ADVISORY COMMITTEE TERMS OF REFERENCE*

PURPOSE

1. recommend strategic directions,
2. anticipate potential challenges and identify needed courses of action,
3. critique work plans/resource materials, and
4. provide expert input to Manager, Special Projects (Records Management & Accreditation) on issues related to building, operating and sustaining a Records & Information Management Program.

ACCOUNTABILITY

The Advisory Committee advises the Manager of Special Projects, (Records Management & Accreditation) who is responsible for managing the overall functioning and day to day operations of the Health Unit's Records & Information Management Program. The Manager reports to the Medical Officer of Health and Chief Executive Officer, who has the ultimate decision-making authority.**

MEMBERSHIP

The following membership supports a skill-based and end-user group committee:

- Manager, Special Projects (Records Management and Accreditation), Chair
- CEO/MOH
- Director, Information Technology
- Health Unit Librarian
- Manager, Privacy and Occupational Health & Safety
- Procurement & Operations Administrator
- 1 Program Manager
- 3 staff representatives, i.e. 2 program staff, 1 administrative staff

Administrative support to be assigned by Directors Committee.

TERM OF MEMBERSHIP

Membership will be reviewed on an annual basis. Term is renewable.

FREQUENCY OF MEETINGS

At a minimum, meetings will be held three (3) times per year, i.e. early in new year, spring and fall. Additional meetings will be at the call of the chair. Where feasible and appropriate, business will be conducted by email in between regularly scheduled meetings to reduce the frequency of additional meetings. A meeting schedule will be confirmed at the beginning of the year.

AGENDAS

Members will be invited to identify agenda items. The agenda will be prepared by the Chair with the assistance of administrative support staff and distributed to members at least three working days prior to a regularly scheduled meeting. Members, who have requested or been asked to speak to an agenda item will be identified on the agenda. The Chair will call for additional agenda items at the beginning of each meeting; as much as possible these items should be identified before the agenda is distributed to ensure members are prepared to participate.

MINUTES

The minutes will be recorded by designated administrative support staff; reviewed by the Chair prior to distribution to members; and posted on the Intranet after they have been approved by the Advisory Committee.

DECISION-MAKING

Recognizing that the mandate of the Advisory Committee is to provide expert advice and consultation, the preferred method of decision-making will be by consensus i.e. everyone can support the final decision, yet may not fully agree. Where differences exist, every effort will be made to understand the issue and why there are different perspectives to ensure that the outcome best serves a sustainable Records & Information Management Program. Where differences can not be resolved, the Chair will consult with the CEO/MOH, who holds the ultimate decision-making authority.

* adapted from Policy 1-031, Appendix B- Guidelines for the Development of Terms of Reference
** adapted from Terms of Reference- Directors Committee – Policy 1-030

2011 03 24

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 038-11

TO: Chair and Members of the Board of Health
FROM Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Medical Officer of Health Activity Report – April

Recommendation
It is recommended that Report No.038-11 re Medical Officer of Health Activity Report – April be received for information.

The following report highlights activities of the Medical Officer of Health since the last Board of Health meeting.

Considerable progress has been made on the development and implementation of the Records Management System for the Health Unit. Under the leadership of Ms. Charlene Beynon, Manager, Special Projects, the Senior Management Team (Directors Committee) finalized, for Board of Health review, a proposed Records Classification System. This is incorporated in a revised Policy 6-030 which is to be titled, Health Unit Records – Establishment, Record Classification, Retention and Disposal. The revised policy is the subject of Board of Health Report No. 037-11, this agenda.

Interviews were conducted for a Manager, Special Projects (Records Management and Accreditation). This position will oversee the implementation of the new Records Classification System. An update on the recruitment process will be provided at the April 14th Board of Health meeting.

Progress continues to be made on the development of the Strategic Plan (see Board of Health Report No. 039-11, this agenda). Ms. Maria Sanchez-Keane, Centre for Organizational Effectiveness, will provide a status update at the April 14th Board of Health meeting.

Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Diseases and Sexual Health Services, and the Medical Officer of Health met with Board Member, Ms. Denise Brown, to discuss fluoridation of drinking water. One item included as part of this meeting, was the United States National Research Council Report on Fluoridation which is the subject of Board of Health Report No. 040-11, this agenda.

Other meetings involving the Medical Officer of Health since the last Board of Health meeting included: a meeting with representatives of the Canadian Latin American Association, London Office, to discuss access to programs and services in Spanish; a teleconference meeting with Dr. Henry Kurban, Acting Medical Officer of Health, Thunder Bay District Health Unit for whom the Medical Officer of Health is providing supervison; attendance at the retirement reception for Ms. Ann Chase, Program Assistant, who has been with the Health Unit for approximately 27 years; attendance at a Ministry of Health and Long-Term Care – Ontario Medical Association Technical Working Group meeting; attendance at the Joint Association of Local Public Health Agencies (alPHa), Ontario Public Health Association (OPHA) and Ontario Agency for Health Protection and Promotion Conference. The Medical Officer of Health also took one week vacation.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 039-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Strategic Planning

Recommendation
It is recommended that Report No. 039-11 re Strategic Planning be received for information.

For the past ten months, the Board of Health initiated Strategic Planning process has been underway facilitated by Ms. Maria Sanchez-Keane, Principal Consultant, Centre for Organizational Effectiveness. This process has been overseen by a steering committee comprised of the Senior Management Team (Directors Committee) and Board of Health representatives: Chair, Ms. Pat Coderre and Vice Chair, Ms. Viola Poletes-Montgomery. Past Board member Mr. Walter Lonc was a member of the Steering Committee until December 2010.

A tremendous amount of work has been accomplished. Ms. Maria Sanchez-Keane will attend the April 14th Board of Health meeting to provide an update on what has been completed to date and the planned next steps to complete the strategic planning process.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 040-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Review of the U.S. National Research Council's Report Entitled Fluoride in Drinking Water, A Scientific Review of EPA's Standards

Recommendation
It is recommended that the attached document entitled "Review of the U.S. National Research Council's Report Entitled 'Fluoride in Drinking Water, A Scientific Review of EPA's Standards' " be received for information.

Staff members were asked to provide a review of the United States National Research Council's 2006 report entitled *Fluoride in Drinking Water, A Scientific Review of EPA's Standards*. The EPA refers to the Environmental Protection Agency which requested the U.S. National Research Council to conduct a scientific review which is summarized in their report. The Health Unit's review of the National Research Council report is provided in the attached document (Appendix A). The Summary of the National Research Council report can be found in the appendix of the attached document and the full National Research Council report, including references and appendices, can be found at http://books.nap.edu/catalog.php?record_id=11571 .

The National Research Council report was intended to assess the acceptable levels for naturally-occurring fluoride in drinking water in the United States. The acceptable levels for naturally-occurring fluoride in drinking water are higher in the U.S. than in Canada (2-4 mg/L in the U.S. compared to 1.5 mg/L in Canada). It should be noted that National Research Council report was not intended to address drinking water where fluoride is added to prevent tooth decay. Fluoride is currently added to a level of 0.7-1.2 mg/L in the U.S. and 0.7 mg/L in Canada. There is a recommendation in the U.S. to lower the level of adjusted fluoride in drinking water to 0.7 mg/L.

The attached document provides background information to assist in understanding the fluoride values, epidemiologic studies and statistics used in the National Research Council report. It then reviews the information provided in the various chapters of the National Research Council report that discuss fluoride and specific body systems. For each chapter, the information in the National Research Council report is briefly reviewed and additional information and context added with regard to the potential implications from adjusted fluoride in London's drinking water supply. A summary of the findings and relevant context information can be found in Table 3 of the attached document.

This report was prepared by Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health

APPENDIX A

Review of the U.S. National Research Council Report:

Fluoride in Drinking Water

A Scientific Review of EPA's Standards

MIDDLESEX-LONDON HEALTH UNIT

April 12, 2011

For information, please contact:

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Review of the U.S. National Research Council Report: *Fluoride in Drinking Water – A Scientific Review of EPS's Standards*
London, Ontario: Author

Author: Bryna Warshawsky, MDCM, MHSc, FRCPC
Associate Medical Officer of Health
Director, Oral Health, Communicable Disease and Sexual Health Services

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TABLES

A. INTRODUCTION

This document was prepared in response to a request to provide a review of the United States National Research Council of the National Academies 2006 report entitled "Fluoride in Drinking Water, A Scientific Review of EPA's Standards" (subsequently referred to as the National Research Council report). The National Research Council was asked to prepare their report by the U.S. Environmental Protection Agency (EPA) which is required to periodically review exposure to contaminants in drinking water under that country's Safe Drinking Water Act. The National Research Council report was intended to assess the maximum contaminant level (MCL) and secondary maximum contaminant level (SMCL) for naturally-occurring fluoride in drinking water in the United States.

It is very important to note that the National Research Council report was not intended to address drinking water where fluoride is added to prevent tooth decay. The report explicitly states that "this report does not evaluate nor make judgments about the benefits, safety, or efficacy of artificial water fluoridation"[1]. In the United States (U.S.), the current recommended levels for adjusting fluoride in drinking water are between 0.7 and 1.2 mg/L[2]. In Canada, the optimal concentration of fluoride in drinking water to promote dental health is set at 0.7 mg/L[3]. Health Canada is also preparing the final version of a report that will assess the Maximum Acceptable Concentration (MAC) for fluoride in drinking water in Canada which is set at 1.5 mg/L. A draft of the Canadian report[4] closed for public comment in November 2009 and the final version is expected shortly.

The maximum contaminant level (MCL) in the United States is to be as close to the level where no adverse health effects are expected to occur with a margin of safety that is considered "adequate". In the U.S., the maximum contaminant level for fluoride was set at 4 mg/L in 1984 in order to prevent crippling fluorosis from fluoride intake. The secondary maximum contaminant level (SMCL) is 2 mg/L and it was set to prevent objectionable tooth enamel fluorosis. At levels above 4 mg/L, naturally fluoridated water would not be considered a safe source of drinking water. At levels between 2 and 4 mg/L, a notice about the potential risk for enamel fluorosis must be sent to the people drinking the water.[5] In Ontario, local public health units are required to raise public and professional awareness to control excess exposure from other sources when naturally-occurring fluoride levels in drinking water are between 1.5 mg/L and 2.4 mg/L[6]. In the Village of Thorndale, where naturally-occurring fluoride levels occasionally exceed 1.5 mg/L, annual notices accompany water bills that are sent directly to all water customers.

The National Research Council report was prepared by a committee specifically convened for this review entitled the "Committee on Fluoride in Drinking Water". The Committee consisted of 12 members including dentists, physicians, epidemiologists, toxicologists and other scientists, with varying views on water fluoridation. The Committee reviewed information related to fluoride with a focus on research since 1993, since research published prior to this time period had been covered in a previous National Research Council report. The Committee heard presentations from many

sources and reviewed published research articles, literature reviews, position papers and unpublished data[7].

The Summary of the National Research Council report is provided in Appendix A. It provides an overview of the findings of the report. The full report, including references and appendices, is over 500 pages long and can be found at http://books.nap.edu/catalog.php?record_id=11571 .

This review document will provide background information to assist in understanding the fluoride values, epidemiologic studies and statistics used in the National Research Council report. Section D will review the information provided in the various chapters of the National Research Council report that discuss fluoride and specific body systems. For each chapter, the information in the report will be briefly summarized and additional information and context will be added with regard to the potential implications from adjusted fluoride in London's drinking water. Three communities in Middlesex County (Arva, Ballymote and Delaware) also receive drinking water to which fluoride is added. As this water is provided from the City of London's system, this document will only make reference to the City of London's drinking water supply.

B. INTERPRETING THE NUMBERS

The following provides an overview of the numbers that are commonly encountered in the National Research Council report and in other information related to fluoride.

B.1 Fluoride in drinking water

IMPORTANT POINT
Target for fluoridation of London's drinking water: 0.7 mg/L (or ppm)

Fluoride in drinking water is expressed in "milligrams per litre (mg/L)" which is the same as "parts per million (ppm)". It is easiest to understand as mg/L. As an example, the target for fluoridating drinking water in London is set at 0.7 mg/L. This means that a person who drinks 1 litre of water will consume 0.7 milligrams (mg) of fluoride. Table 1 outlines some of the commonly referred to fluoride parameters related to drinking water.

Table1. Commonly referred to fluoride parameters related to drinking water

Level	Significance	Comments
0.7 mg/L	Target level for adjusting fluoride in London's drinking water. Optimal concentration of fluoride in drinking water to promote dental health in Canada.	Typical water consumption in the US is estimated at approximately 1 litre per day[8]. Assuming this is the same in London, 0.7 mg of fluoride will typically be consumed from fluoridated water per day. In the U.S. it is estimated that 90% of people drink approximately 2 litres or less of water per day[9]. Assuming this is the same in London, 90% of people will consume 1.4 mg or less of fluoride from drinking water per day.
0.7 to 1.2 mg/L	Current target level for adjusting fluoride in drinking water in the U.S.	New recommendation to reduce the target level to 0.7 mg/L have been recently proposed[10].
1.5 mg/L	Maximum Acceptable Concentration (MAC) for natural fluoride levels in drinking water in Canada.	When naturally-occurring fluoride levels are between 1.5 and 2.4 mg/L, consumers and professionals in Ontario must be advised of the possible risk of dental fluorosis and measures to be taken to reduce this risk.
2 mg/L	Secondary maximum contaminant level in the U.S.	When naturally-occurring fluoride levels are between 2 and 4 mg/L, consumers in the U.S. must be advised of the possible risk of dental fluorosis and the measures to be taken to reduce this risk.
4 mg/L	Maximum contaminant level in the U.S.	When naturally-occurring fluoride levels exceed 4 mg/L, this water should not be used as a source of drinking water.

B.2 Daily intake of fluoride from all sources

Health Canada produced an estimate of tolerable daily intake to prevent moderate and severe dental fluorosis in those who are most vulnerable (children 1 – 4 years of age). The tolerable daily intake was estimated to be 0.105 mg/kg/day (milligram per kilogram per day)[11] (also expressed as 105 μg/kg/day – micrograms per kilogram per day). Using this estimate of 0.105 mg/kg/day, a child weighing 13 kg can consume 1.37 mg of fluoride per day without a risk of moderate dental fluorosis. Only children less than 6-8 years of age are at risk for dental fluorosis, since this is when the permanent teeth are forming, with 22 – 26 months being the period of maximum risk for the front teeth[12].

The tolerable daily intake estimate of 0.105 mg/kg/day is consistent with the U.S. Institute of Medicine's tolerable upper intake of 0.1 mg/kg/day for children ages 0 – 8 years[13] [14]. Others have used estimates of 0.05-0.07 mg/kg/day to maximize the prevention of cavities and minimize enamel fluorosis[15] and this range of values is used as a reference point in the National Research Council report.

Health Canada has estimated a tolerable daily intake of fluoride from all sources of:

- 0.105 mg/kg/day (105 μg/kg/day)
    - For a 13 kg child = 1.37 mg/day of fluoride
    - For a 70 kg person = 7.35 mg/day of fluoride

      The average adult consumes about 0.04 mg/kg/day[a] of fluoride from all sources which is 2.8 mg/day of fluoride.

[a] National Research Council. Page 63

Estimated daily intake of fluoride from all sources includes fluoride from water, toothpaste, food and beverages and dental supplements. Various estimates of daily intake are produced in the National Research Council report depending on the concentration of fluoride in the drinking water, the amount of water consumed each day, the amount of fluoride estimated to be in other foods and beverages consumed in areas where the water is fluoridated, and whether fluoride supplements are used.

Table 2 provides some of the daily intake estimates produced in the National Research Council report assuming 1.0 mg/L in drinking water (which is the closest to but exceeds London's water concentration) and no fluoride supplements (which are not recommended in London)[16]. Because Table 2 is based on 1.0 mg/L of fluoride in drinking water and not 0.7 mg/L as in London's water, the daily intake estimates in Table 2 are higher than would be experienced from drinking London's water.

Using a cut off of 0.05-0.07 mg/kg/day for optimal daily intake (as was used in the National Research Council report), the estimated daily intake will be exceeded for non-nursing infants using all methods of calculating daily water intake. Using the tolerable daily intake of 0.105 mg/kg/day (as proposed by Health Canada), the tolerable daily intake is not exceeded for two methods of estimating daily intake of fluoride (i.e. it is not exceeded in column A or B of Table 2). Using the estimate that maximizes the amount of water consumed per day (i.e. column C of Table 2), the tolerable daily intake is exceeded for children less than 5 years of age. However, even if the tolerable daily intake is exceeded for children, Health Canada notes that the rates of severe and moderate dental fluorosis in Canada are very low, which may indicate that the tolerable daily intake set by Health Canada is overly conservative[17].

Table 2: Total estimated chronic inorganic fluoride exposure from all sources (tap water, non-tap water (bottled water), food, toothpaste and air) in mg/kg/day assuming water is fluoridated at 1.0 mg/L and no fluoride supplements

Population Subgroups	**A** **Assumes non-tap water is 0.5 mg/L; Assumes total daily water consumption based on a model[18]**	**B** **Assumes non-tap water is 1.0 mg/L; Assumes total daily water consumption based on a model[19]**	**C** **Assumes non-tap water is 1.0 mg/L; Assumes water consumption is 1 litre per day for a 10-kg child and 2 litres per day for 70-kg adult[20]**
All infants (<1 year)	0.070	0.082	0.113
Nursing	0.030	0.034	0.109
Non-nursing	0.087	0.100	0.115
Children 1-2 years	0.066	0.070	0.139
Children 3-5 years	0.060	0.063	NA
Children 6-12 years	0.040	0.042	NA
Youth 13-19 years	0.028	0.030	NA
Adults 20-49 Years	0.031	0.034	0.043
Adults 50+ years	0.031	0.034	0.042
Females 13-49 years	0.031	0.033	0.042

KEY POINT
Tolerable daily intakes of fluoride are set to prevent severe and moderate dental fluorosis in children most at risk (ages 1 - 4 years). Although these levels of intake may be exceeded in children at 1.0 mg/L of fluoride in drinking water based on some estimates, they are less likely to be exceeded at 0.7 mg/L of fluoride in London's drinking water. Rates of severe and moderate fluorosis in Canada are very low indicating fluoride levels in drinking water in Canada are sufficiently protective.

B.3 Fluoride in bones

Bone ash is a white powdery substance that results from burning bone. As bone accumulates fluoride, the amount of fluoride in bone ash is presented as a measure of fluoride exposure. Normal values have ranged from 326-2,390 ppm[21].

B.4 Fluoride in other tissues

In the National Research Council report, measures of the range of fluoride in other body fluids and body parts such as urine, blood (plasma and serum), saliva, hair, plaque, toe nails, finger nails etc are provided[22].

C. UNDERSTANDING THE STUDIES

The National Research Council report reviews numerous studies of different types or designs. The studies involve looking at the impact of fluoride on animals and people. The outcomes of the studies include changes in the genetic material of cells, changes in hormones or chemicals in the body, changes in fluoride levels in various tissues or organs in the body and the development of disease states. There are strengths and weaknesses inherent in the design of these studies and additional strengths and weaknesses related to how well the studies were performed by the researchers.

When trying to draw conclusions from various studies, each study needs to be assessed individually with regard to design and quality. Then all of the studies need to be assessed in totality to determine the strength of the picture they are portraying. Conclusions are usually drawn by a group of experts looking at the totality of the evidence; these are called systematic reviews. Conclusions are easiest to draw when all studies have strong designs, are well performed and all of the studies find consistent results. Conclusions are hardest to draw when the studies are of weaker design, are executed poorly and/or the findings are inconsistent.

It is important to note that large effects are typically easy to determine. This means that if fluoride caused high rates of a disease or condition, this would be easy to find even using weaker study designs. In addition, when there is a large effect the results of different studies are more likely to be consistent. Sometimes large effects are obvious just by observation such as the effect of high levels of fluoride on dental fluorosis which was noted by practicing dentists in communities with very high levels of naturally-occurring fluoride. In contrast, small effects are much harder to find and require more studies with stronger designs that are well executed.

The following sections provide a general overview of the types of studies found in the National Research Council report. They are listed from the weakest design to the strongest design in terms of ability to reliably inform conclusions about human health impacts. A brief overview of the statistics used in these reports is also provided.

C.1 Genotoxicity studies and other in vitro studies

Genotoxicity studies look at the effects of fluoride on the genetic material of cells. The cells can be exposed to fluoride outside of the body (in vitro) or in the body (in vivo). The cells can be of animal or human origin. The effect of fluoride on animal cells of the parathyroid and pineal gland in vitro are also discussed in the National Research Council report.

C.2 Animal studies

These studies expose animals to fluoride and then look at fluoride levels in various tissues or organs in the body, and/or at the impact on biochemical substances, hormones, behaviours or disease states. Studies in animals often use high doses of fluoride. The higher doses may be used because the animal's body may handle the fluoride differently than the human body, or may be intended to compensate for the fact that the studies are often of shorter duration than human exposures. Animal studies provide more informative results if the disease state is similar in the animal and in humans, and if the substance of interest (e.g. fluoride) is handled similarly in the animal and human body. Animal studies can be useful to generate hypotheses to be further studied in humans but their results must be considered along with human studies which are more applicable to the impact on humans.

C.3 Human studies (epidemiologic studies)

Studies of humans are called epidemiologic studies. There is a hierarchy of design among human studies. The study designs reviewed in the National Research Council report are listed below from weakest to strongest design.

C.3 i) Ecologic studies: These studies compare disease rates and exposure rates at the community level, rather than the individual level. For example, an ecologic study compares the rates of cancer among several communities according to the community's level of fluoride in water. These studies are a weak design because the researchers cannot be certain if the people with the disease (e.g. the people with cancer) were actually exposed to the substance of interest (e.g. fluoride) and to what extent. Researchers can only know the average rates of exposure in the community. As well, there can be many differences between the communities being compared aside from their levels of fluoride in water. These factors are not always recognized and cannot always be controlled for in this type of ecologic study.

C.3 ii) Semi-ecologic studies: In these studies, a group of people with a disease (e.g. a type of cancer) is compared to a similar group of people without the disease (called controls) with regard to the exposure of interest (e.g. water fluoride levels). In a semi-ecologic design, the exposure of interest (e.g. fluoride) is not determined for each individual in the study based on interviews of each person, but rather based on the general fluoride level of the community where the individual lives.

C.3 iii) Case-control studies: These studies are similar to semi-ecologic studies, in that a group of people with a disease (called cases) are compared to a similar group of people without the disease (called controls) with regard to the exposure of interest. However, a case-control study is a stronger design than a semi-ecologic study because each individual in the study is interviewed and their individual level of exposure is determined (e.g. total fluoride intake for each individual from various sources). Other important factors that may lead to disease can also be determined in the interview with each individual so that these factors can be compared between the cases and controls.

Case-control studies are good for studying diseases that occur infrequently. One weakness of case-control studies is that people are often asked to remember what they did many years ago and this information may be remembered differently between cases and controls. It is also important to choose the controls carefully to ensure that they come from a population that is generally similar to the cases.

C.3 iv) Cohort studies: These types of studies involve looking at one specific population and then comparing the disease rates of a group of people within the larger population who were exposed to a substance (e.g. fluoride), to another group within the population without that type of exposure. Occupational studies can be a cohort design, where a group of workers exposed to fluoride are compared to a group of workers who are not exposed to fluoride. In cohort studies it is important to determine if other relevant risk factors (e.g. smoking, drinking) are similar between the two groups in order to attribute any difference in disease rates to the exposure of interest (e.g. fluoride). Workers in occupational settings are often exposed to levels of fluoride that are much higher than those found in drinking water.

C.3 v) Randomized control trials: These represent the strongest type of epidemiological study. This type of study involves taking a group of people and randomly assigning one part of the group to receive the intervention (e.g. fluoride) and the other part of the group to receive a placebo (something that looks like fluoride but has no biologic activity). The entire group is then followed forward in time to see if they develop the outcome of interest (e.g. prevention of cavities or fractures). It is very difficult to study water fluoridation using a randomized control design, however, there are some studies that assess the use of fluoride in the treatment of osteoporosis. The researchers randomly assign people with osteoporosis to receive daily fluoride pills or to receive a placebo. These people are then followed forward in time to determine the impact of fluoride on the bone and to determine if one group is more or less likely to develop fractures. The problem with these studies is that the daily amount of fluoride used was substantially higher than the amount of fluoride that would be consumed in fluoridated water.

IMPORTANT POINT
Large effects are easy to find in epidemiologic studies. Smaller effects are more difficult to determine.

C.4 Statistics

In the National Research Council report, the numbers often used to assess whether fluoride increases or decreases the risk of a disease is called “the relative risk (RR)”. The relative risk is the rate of the disease in those exposed to fluoride divided by the rate of the disease in those not exposed to fluoride.

$$\text{Relative risk (RR)} = \frac{\text{rate of disease in those exposed to fluoride}}{\text{rate of disease in those NOT exposed to fluoride}}$$

A result of “1.00” would therefore indicate no risk. A protective effect from fluoride would result in a number less than 1.00 and an increased risk would result in a number greater than 1.00. The further the number is away from 1.00 the greater the potential risk or benefit from fluoride. The results of the study are more convincing if the relative risk increases progressively with increasing levels of exposure to fluoride. This is called a “dose response” relationship. In some studies, the term “odds ratio (OR)” is used. It works the same way as the relative risk.

Confidence limits are often attached to the relative risk or odds ratio. These are two numbers, a lower limit and an upper limit. The 95% confidence limit means that there is a 95% chance that the true value of the relative risk or odds ratio falls somewhere between the two numbers in the confidence limit. If the confidence limit contains the value “1.00”, the result is deemed to be “not statistically significant”, meaning that any increased or decreased risk, as indicated by the relative risk or odds ratio, may not be related to fluoride but to chance alone. If the confidence limit does not include the value 1.00, the relative risk or odds ratio is deemed to be “statistically significant” and likely to be due fluoride and not just to chance.

Sometimes, instead of a confidence limit, the statistic associated with the relative risk or odds ratio is a “p-value”. A p-value greater than 0.05 ($p>0.05$) means that the relative risk or odds ratio results are ‘not statistically significant”, meaning that any increased or decreased risk, as indicated by the relative risk or odds ratio, may not be related to fluoride but to chance alone. If the p-value is less than or equal to 0.05 ($p \leq 0.05$), the relative risk or odds ratio is deemed to be “statistically significant” and likely to be due fluoride and not just to chance.

D) FLUORIDE AND SPECIFIC BODY SYSTEMS

The following section of this document will provide a general overview of the findings of the National Research Council report for each body system. Context for interpreting the findings in relation to the fluoridation of London's drinking water is also provided.

D.1 Teeth[23]

General Findings

It should be noted that the National Research Council was asked to look at the adverse effects that might result from fluoride and not its beneficial effects in preventing tooth decay[24]. The report found that severe fluorosis (disruption of the surface of the enamel caused by fluoride) is extremely unlikely to occur at levels of fluoride in drinking water below 2.0 mg/L. This level of fluoride in drinking water will not completely prevent moderate fluorosis (brown discoloration of teeth) but will reduce the severity and occurrence to 15% or less of the population[25].

Context

A U.S. survey conducted between 1999 and 2004 found that 3.6% of 12-15 year olds had moderate or severe fluorosis, 8.6% had mild fluorosis, and 28.5% had very mild fluorosis[26]. Mild and very mild fluorosis are generally only noticeable by a dental health professional. By comparison, in Health Canada's Canadian Health Measures Survey conducted between 2007 and 2009, the investigators found no severe and almost no moderate fluorosis in children between 6 and 12 years of age. Mild and very mild fluorosis were identified in 4% and 12% of these children respectively[27].

Fluorosis rates are expected to be higher in the U.S. than in Canada because the U.S. range for adjusting the fluoride in drinking water is 0.7 to 1.2 mg/L, while in Canada it is lower, at 0.7 mg/L. There is a recommendation in the U.S. to move fluoridation levels to 0.7 mg/L as well. The acceptable levels for naturally-occurring fluoride in drinking water are also higher in the U.S. than in Canada (2 - 4 mg/L in the U.S. compared to 1.5 mg/L in Canada).

D.2 Musculoskeletal Effects[28] (Bone and Joints)

D.2 i) Fractures[29]

General Findings

Because fluoride accumulates in the bone, there has been a lot of attention given to its effect on bone. The National Research Council report outlines a variety of hypotheses with regard to how fluoride affects the bones, including its effects on osteoblasts (the

cells that make bone) and osteoclasts (the cells that break down bone). It is known that fluoride increases the density of bones and it was used in the past as a medication to treat osteoporosis in the hope of preventing fractures. Studies using high doses (20 to 34 mg/day) of fluoride to treat osteoporosis in humans have indicated that it may slightly decrease vertebral fractures (fractures of the spinal bones) and may increase the risk of non-vertebral fractures (e.g. hips, wrist etc.) after 4 years of use[30].

Five studies of fracture risk related to drinking water containing near 4 mg/L of fluoride were reviewed in the National Research Council report and indicated an increased risk of fractures[31]. The Committee concluded that "the weight of evidence supports the conclusion that lifetime exposure to fluoride at drinking water concentrations of 4 mg/L is likely to increase fracture rates in the population, compared with exposure to fluoride at 1 mg/L, particularly in some susceptible demographic groups that are prone to accumulating fluoride into their bones"[32].

When looking at fluoride concentrations around 2 mg/L, the National Research Council Committee assessed four studies and concluded that the "available epidemiologic data for assessing bone fracture risk in relation to fluoride exposure around 2 mg/L is suggestive but inadequate for drawing firm conclusions about the risk or safety of exposures at that concentration"[33]. The National Research Council report also commented on the review done by McDonough et al. at York University in the United Kingdom in 2000. This review of multiple fracture studies compared the fracture risk in fluoridated areas at approximately 1.0 mg/L to non-fluoridated areas and concluded that the studies were evenly distributed around the no effect mark, but that statistical testing showed significant heterogeneity among studies (meaning the variation in the results of the studies made it difficult to combine them to get a single estimate of the risk)[34].

Context

The McDonough et al. review done by York University is most relevant to fluoride in drinking water at the levels used in London (0.7 mg/L). It reviewed 29 studies that assessed the fracture risk of water fluoridated at levels closest to 1.0 mg/L compared to the lowest water fluoride level reported and concluded "The best available evidence on the association of water fluoridation and bone fractures (27 of 29 studies evidence level C – *Level C" means: lowest quality of evidence, high risk of bias*) show no association."[35] Similarly, a later review published by the Australian Government in 2007 concluded the following: "The authors of the three existing systematic review [sic] concur that water fluoridation at levels aimed at preventing dental caries has little effect on fracture risk – either protective or deleterious. The results of the subsequent original studies support this conclusion, although suggest that optimal fluoridation of 1 ppm may indeed result in a lower risk of facture when compared to excessively high levels (well beyond those experienced in Australia). One study also indicated that optimal fluoridation levels may also lower overall fracture risk when compared to no fluoridation (the latter was not the case when hip fractures were considered in isolation)."[36]

D.2 ii) Skeletal fluorosis[37]

General Findings

Previous recommendations regarding the Maximum Contaminant Level of 4 mg/L were intended to prevent severe skeletal fluorosis (clinical stage III), a condition where fluoride accumulates in the bone and results in crippling calcifications in the joints, ligaments and vertebral bodies. The National Research Council Committee agreed that clinical fluorosis stage II was also a significant health concern as it resulted in joint pain, arthritic symptoms, calcification of ligaments and changes in some types of bone (osteosclerosis). Stage III skeletal fluorosis appears to be rare in the United States. The Committee could not determine if stage II skeletal fluorosis is occurring in U.S. residents who drink water with fluoride at 4 mg/L[38].

Context

Skeletal fluorosis should not be a risk from water that has adjusted fluoride levels. Health Canada estimates that potentially adverse effects associated with skeletal fluorosis are likely to be observed at fluoride intakes greater than approximately 0.20 mg/kg/day[39], which is almost 5 times the estimated daily intake for an adult in the U.S. when the water fluoridation level is 1 mg/L. Other studies suggested that an intake of at least 10 mg/day for more than 10 years is needed to produce clinical signs of the milder forms of skeletal fluorosis[40].

D.2 iii) Arthritis[41]

General Findings

Based on the small number of studies and their conflicting results, the National Research Council Committee determined that there is likely to be no effect of fluoride on arthritis at environmental doses[42].

D.3 Reproductive and developmental effects[43]

General Findings

This section of the National Research Council report looked at the impact of fluoride on reproductive effects, such as hormone levels and fertility, in both males and females. The findings in this section are based mostly on animal studies which, in general, exposed the animals to high doses of fluoride. The National Research Council Committee concluded that “High-quality studies in laboratory animals over a range of fluoride concentrations (0-250 mg/L in drinking water) indicate that adverse reproductive and developmental outcomes occur only at very high concentrations”[44]. There are few available human studies on reproductive effects of fluoride, some assessing high doses

of fluoride. The National Research Council Committee concluded that "Overall, the available studies of fluoride effects on human reproduction are few and have significant shortcomings in design and power, limiting inferences"[45].

Down's syndrome related to fluoride in drinking water has been assessed in several studies. Two early papers from the 1950s and 1960s[46 47] suggested an association between elevated rates of Down's syndrome and high water fluoride concentrations, with one also suggesting an association in babies born to younger women. However, these studies had several problems with the way they were conducted. Four other studies concluded that there was generally no association between Down's Syndrome and fluoride, although one study suggested a possible association among births to younger women[48]. There were problems with the methods of some of these studies as well. Problems with the Down's syndrome studies included not being sure that all the cases of Down's syndrome had been included into the analyses and not always controlling for the age of the mothers, since Down's syndrome is known to occur more often in babies of older mothers.

A review of the literature conducted in 2001 stated that an association between water fluoride concentrations and Down's syndrome was inconclusive[49]. Overall, the National Research Council report concluded that "studies of fluoride's effects on human development are few and have some significant shortcomings in design and power, limiting their impact"[50]. The reports also states "A few studies of human populations have suggested that fluoride might be associated with alterations in reproductive hormones, fertility, and Down's syndrome, but their design limitations make them of little value for risk evaluation." [51]

Context

The review of Down's syndrome and fluoride conducted in 2001 summarized six studies, five conducted in the US and one from England comparing Down's syndrome rates in fluoridated and non-fluoridated areas. The authors of the review noted that "This systematic review suggests that the evidence for an association between water fluoride level and the incidence of Down's syndrome is weak, and that all the identified studies were of poor quality" [52]. Studies looking at high dose fluoride exposure and Down's syndrome do not appear to have been conducted.

D.4 Neurotoxicity and neurobehavioral effects[53]

General Findings

The National Research Council report reviews three studies that compared the results of intelligence quotients (IQ) testing in pairs of Chinese villages - one with high and the other with lower levels of fluoride in drinking water. As well, one study compared two villages, one with high fluoride levels (as indicated by high levels of moderate to severe dental fluorosis) due to inhaling soot and smoke from domestic coal fires and the other

village with low or no dental fluorosis. These four studies found lower IQs in the villages with higher fluoride exposures. The National Research Council report states that "The significance of these Chinese studies is uncertain. Most of the papers were brief reports and omitted important procedural details"[54] The Committee did indicate that the consistency of the studies' results warranted further study.

A series of rat studies using a method of photographing fluoride and non-fluoride exposed rats in a small box indicated abnormal behaviour only in the rats exposed to the higher levels of fluoride. The National Research Council report noted "The results from these three experiments are difficult to interpret. One difficulty is interpreting the computer-derived categorization of activity patterns compared with behavioural descriptions commonly used by most animal researchers"[55]. A few other animal studies suggest changes in behaviour at very high doses of fluoride intake. The report also describes a few animal studies that compare the effect of aluminum fluoride with sodium fluoride and no fluoride on a small number of rats. The aluminum fluoride appeared to result in more pronounced effects on the rats, but abnormal outcomes and abnormal appearance of the brain were noted in both sets of exposed rats. The National Research Council report hypothesizes about an interaction between aluminum and fluoride in the brain and chemical changes in animal brains.

This chapter of the National Research Council report also discusses the potential impact of silicofluorides (e.g. hydrofluorosilicic acid, which is a type of silicofluoride that is added to the water in London in order to provide fluoride). The report discusses a potential increase in lead exposure or change in chemicals in the brain associated with silicofluorides. The report also quotes authors that concluded that "there is no "credible evidence" that water fluoridation has any quantifiable effect on the solubility, bioavailability or bioaccumulation of any form of lead"[56], arguing that the silicofluorides would be completely hydrolyzed (dissolved) before reaching the consumer's tap.

Context

Several studies have assessed IQ and fluoride levels, all from developing countries, most commonly China. Studies that compare the IQ levels in rural villages are problematic because it is difficult to know if the differences in IQ are true findings or if they are related to other unrecognized, unmeasured exposures. For example, IQ is known to be influenced by thyroid function and lead exposure. Based on the information in the National Research Council report, only one of the IQ studies in this chapter appears to have assessed iodine (which is related to thyroid function) and lead exposures between the villages being compared[57 58].

Even if the findings were true, the average fluoride levels in drinking water in these studies were approximately three to five times higher than London's drinking water, and the applicability of findings in Chinese villages to cities in developed countries is unknown. No studies looking at IQ levels in developed countries related to fluoride exposure appear to have been conducted.

Health Canada's draft report stated "It *(the weight of the evidence)* does not support a link between fluoride exposure and intelligence quotients deficits, as there are significant concerns regarding the available studies, including quality, credibility, and methodological weaknesses"[59]. A fluoride review conducted by the European Commission wrote "SCHER *(Scientific Committee on Health and Environmental Risks)* agrees that there is not enough evidence to conclude that fluoride in drinking water may impair IQ"[60].

The studies of abnormal behaviour in rats exposed to high fluoride levels have also been questioned with regard to their methods. These studies only found effects on the behaviour of the animals at very high concentrations of fluoride and often failed to show effects on the animals at lower concentrations.

As hydrofluorosilicic acid dissolves completely in water, the public is never exposed to this compound and so any hypotheses about its potential effects on the brain are of limited relevance. Adding hydrofluorosilicic acid changes the acid balance in the water, and this is corrected by the water system operators so that the water is not any more corrosive or able to leach lead from the pipes than water without hydrofluorosilicic acid added.

D.5 Endocrine system[61]

General Findings

D.5 i) Thyroid[62]

The National Research Council report hypothesizes that fluoride may interfere with the formation of a thyroid hormone in the tissues in the body. Indirectly, this may result in enlargement of the thyroid gland (which is referred to as a goitre) and a deficiency state referred to as hypothyroid. Hypothyroid states are most commonly attributed to iodine deficiency, which is why iodine is added to salt to ensure sufficient ingestion. The National Research Council report also indicates that selenium deficiencies, which occur in China and Africa, can affect thyroid function[63].

The National Research Council report states that an association between fluoride and thyroid problems was suggested many years ago. In 1923, high rates of goitre were found in a town in Idaho which had high fluoride levels in their drinking water; children born after a switch to a low fluoride water supply "were not so affected"[64]. The report also quotes a study done in 1958 where fluoride was found to alleviate the symptoms of an overactive thyroid in 6 of 15 patients[65], suggesting fluoride may decrease thyroid function.

Several animal studies are quoted in the National Research Council report, some suggesting an association between fluoride and thyroid hormone levels consistent with the above hypothesis, some of which used high fluoride levels and some of which were also in animals that were iodine deficient. In humans, goitre has generally been

attributed to low iodine levels although some areas with goitres were not considered iodine deficient and may be associated with fluoride levels. The National Research Council report includes several human studies, most of which were conducted in developing countries. Some of the studies found no association between fluoride and thyroid function and/or goitre; some showed an association between fluoride and decreased thyroid function and/or goitre in areas with low iodine; and some studies, where iodine was considered adequate, found an association between high levels of fluoride and decreased thyroid function and/or goitre. No changes in thyroid function were noted in two studies of patients treated with higher doses of fluoride for osteoporosis[66].

It was noted in the National Research Council report that "Nutritional information (especially the adequacy of iodine and selenium intake) is lacking for many (iodine) and all (selenium) of the available studies on humans"[67]. It is also noted that "Many of the effects could be considered subclinical effects, meaning that they are not adverse health effects"[68]. The report concluded that adverse effects on health might be associated with seemingly mild changes in hormone concentrations therefore further research is needed to explore these possibilities.[69]

D.5 ii) Thyroid parafollicular cells[70]

The parafollicular cells of the thyroid produce a hormone called calcitonin. Calcitonin inhibits bone resorption (dissolving of bone by cells called osteoclasts). No animal studies measured calcitonin levels in relation to fluoride exposure. The few human studies involved people with skeletal fluorosis or workers exposed to high levels of fluoride and did find associations with increased calcitonin levels.

D.5 iii) Parathyroid glands[71]

Four small parathyroid glands are located at the back of the thyroid. They secrete a hormone called parathyroid hormone which controls the calcium levels in the blood. Animal studies, which generally use high levels of fluoride, suggest that fluoride increases the level of parathyroid hormone, particularly if there is also low calcium intake. Some studies in humans involving individuals receiving fluoride treatment for osteoporosis, having high occupational fluoride exposure or having endemic skeletal fluorosis suggested that fluoride may have an effect on calcium levels and/or parathyroid hormone levels. Various interactions between fluoride and the parathyroid glands are discussed.

D.5 iv) Pineal gland[72]

The pineal gland is a small organ located near the center of the brain. It produces a hormone called melatonin which is involved in the sleep-wake cycle and the onset of puberty and menopause. The pineal gland is calcified and because fluoride interacts with calcified tissues, the impact of fluoride on the pineal gland is of interest. The National Research Council report reviews one animal study and two human studies. The animal study used high doses of fluoride and found some effects on melatonin

production and sexual maturation. The two human studies compared the age of puberty for girls in fluoridated versus non-fluoridated or low fluoridated communities; the researchers generally found no significant difference between the two communities although one study suggests that the average age of onset of menstruation was earlier in a U.S. town with a fluoridated water supply compared to a town with an unfluoridated water supply[73].

D.5 v) Glucose intolerance[74]

Diabetes results from the body's inability to manage glucose. A small number of animal studies in diabetic and normal animals suggest that high doses of fluoride may impact the body's ability to handle glucose. Few human studies are presented, most involving populations with high exposures to fluoride. Some studies suggest an impaired tolerance of glucose and others do not.

Context

The endocrine chapter of the report appears to be one of the more complicated sections. Multiple endocrine organs are reviewed in considerable detail and several hypotheses are proposed. Animal studies generally involve high doses of fluoride and are not applicable to the low levels of fluoride in drinking water. The human studies also often used high levels of exposure such as doses once used to treat osteoporosis, doses in occupational exposures or exposures in areas with high levels of fluoride in the drinking water. The studies with high levels of fluoride in drinking water were often conducted in developing countries where there may be other nutritional factors that impact the results. The few human studies of the thyroid done in developed countries[75] [76] [77] do not show an impact on goitre (two studies) or thyroid function (one study).

The author(s) of this section of the National Research Council report attempt to calculate the levels of exposure in the subjects in the various studies (expressed as mg/kg/day) in a summary table[78]. These are, however, estimates only[79] and the report does not indicate in the summary table that many of the estimates are from people with evidence of high exposures to fluoride as manifested by skeletal fluorosis and/or severe enamel fluorosis. In addition, some of the estimates are based on very small numbers of subjects. The summary table also only highlights the studies that support an association and not the studies that indicate no association.

Very few studies were done to assess the impact of fluoride on thyroid parafollicular cells, the pineal gland or glucose intolerance and with the exception of studies of the pineal gland, most involved exposures to high levels of fluoride. For all the endocrine organs, the National Research Council report provides very little evidence to indicate that any effects would occur at the low levels used in adjusted drinking water. A recent review by the European Commission states that "A systematic evaluation of the human studies does not suggest a potential thyroid effect at realistic exposures to fluoride"[80]. A review of recent conventional sources of medical information reveals that fluoride exposure is not discussed as a cause of hypothyroidism or diabetes [81] [82] [83] [84] [85] [86] [87].

D.6 Gastrointestinal, renal, hepatic and immune system[88]

General Findings

D.6. i) Gastrointestinal[89]

A few case reports suggested that fluoridated water at 1.0 mg/L could result in gastrointestinal symptoms (nausea, vomiting, and abdominal pain) in some people. The National Research Council report suggests that these people may be particularly hypersensitive, although this was uncertain[90]. The report indicates that fluoride at 4 mg/L in the drinking water results in approximately 1% of the population experiencing gastrointestinal symptoms[91]. In areas of high levels of fluorosis, such as India, gastrointestinal symptoms are common, especially where there is poor nutrition. Animal studies that expose animals to levels that are generally between 100 and 1,000 times the blood fluoride levels that occur from drinking fluoridated water illustrate the effect that fluoride can have on the stomach lining and gastrointestinal tract[92]. The effect at 4 mg/L of fluoride in drinking water is not well studied, with most studies involving higher doses of exposure[93].

D.6 ii) Renal (kidneys) [94]

Fluoride is excreted via the kidneys so the kidneys may experience higher concentrations of fluoride than other organs of the body. A few studies have been conducted to explore the effect of fluoride on kidney stones and the findings were mixed, with the possibility of both increased and decreased rates of kidney stones suggested in association with fluoride[95].

There is evidence of temporary declines in kidney function after exposure to general anaesthetic agents which contain fluorine. Administration of these agents results in very high blood levels of fluoride (50 times higher than normal). It is uncertain if the effect on the kidney is due to the fluoride or other compounds that result from the metabolism of the general anaesthetic[96]. Studies of areas where fluorosis is endemic suggest high levels of fluoride may increase the risk of kidney problems in some people[97].The National Research Council report indicates that “There are no published studies that show that fluoride ingestion on a chronic basis at that concentration *(1.0 L per day of water with 1.0 mg/L of fluoride)* can affect the kidney.” [98]

People with impaired kidney function or on dialysis can accumulate fluoride much more quickly than normal. Care must be used in the dialysis process to ensure proper functioning of the equipment to remove fluoride from water.[99]

D.6 iii) Hepatic system (liver) [100]

High doses of fluoride fed to animals can result in changes in the appearance of the liver. One study involving people exposed to high levels of fluoride for 18 months to treat osteoporosis found an increase in blood levels of liver enzymes but the concentrations were still in the normal range[101]. Available data were not deemed sufficient to draw conclusions about low-level, long-term fluoride exposures in humans[102].

D.6 iv) Immune system[103]

The bone marrow (inside of the bone) contains cells that differentiate into the cells of the immune system. In experiments on bone marrow cells outside of the body (in vitro), large doses of fluoride are required to affect the development of immune cells. Given that the amount of fluoride in the bone can be significantly higher than in other areas of the body, the National Research Council report indicates that it is theoretically possible that long term exposure to fluoride at high levels could result in levels in the bone that could affect the immune cells.[104] The effect on the immune system of fluoride from drinking water containing 4 mg/L has not been studied in humans and the effect of fluoride on people with immunodeficiencies has also not be assessed[105].

Context

Aside from a few case reports of people with gastrointestinal upset at 1.0 mg/L, the effects of fluoride on the gastrointestinal, kidney, liver and immune system appear to be related to high levels of fluoride exposure. However, the National Research Council report indicates that there are no human studies that carefully document the impact of 4 mg/L of fluoride on these systems[106]. The report concludes that "such effects are unlikely to be a risk for the average individual exposed to fluoride at 4 mg/L in drinking water. However, a potentially susceptible subpopulation comprises individuals with renal impairment who retain more fluoride than healthy people do"[107]. Given the effects on these systems are unlikely at 4 mg/L, they will be much less likely at lower levels such as the 0.7 mg/L used to fluoridate London's drinking water.

D.7 Genotoxicity and carcinogenicity[108]

General Findings

D.7 i) Genotoxicity[109]

Genotoxicity refers to the ability of a substance such as fluoride to produce effects on the genetic material of cells. The cells can be either of animal or human origin and can be exposed to the substance outside of the body (in vitro) or in the body (in vivo). Several of these tests are reported in the National Research Council report. The in vitro studies "are inconsistent and do not strongly indicate the presence or absence of

genotoxic potential of fluoride"[110]. Regarding the in vivo studies, the report states that "the inconsistencies in the results of these in vivo studies do not enable a straightforward evaluation of fluoride's practical genotoxic potential in humans." [111]

D.7 ii) Carcinogenicity[112]

One animal study found that male rats given very high doses of fluoride (100 - 175 mg/L) in their drinking water had a small increased risk of developing osteosarcoma (a rare cancer of the bone) compared to control rats. This effect was not seen in two other studies involving rats exposed to fluoride, although a study in mice showed an increase in noncancerous bone tumours at very high fluoride doses.[113]

The weight of evidence from epidemiological studies of cancer in people done before 1993 did not indicate a cancer risk to humans from fluoride exposures[114]. More recent studies focused mainly on bone cancers because of the results of the animal studies, fluoride's known ability to concentrate in bone and its ability to cause cells in bone to divide. Some studies have compared cancer rates in fluoridated versus non-fluoridated communities (ecologic studies). A few of these studies suggested an association between fluoride and osteosarcoma in young males, while several other studies found no association[115].

Another study design looked at people with osteosarcoma and compared their past exposures to fluoride with a group of similar people without osteosarcoma (case-control studies). True case-control studies use individual interviews to determine past fluoride exposures which give a more precise understanding of the level of exposure, although some studies use the general fluoride level of where the person lives to estimate their fluoride exposures (semi-ecologic studies). Two of these studies (one case-control and one semi-ecologic study) generally did not indicate an association between fluoride exposure and osteosarcoma. A case-control study by Bassin et al., which was done for her PhD research at Harvard, found an association between osteosarcoma and fluoride levels in boys, based on the fluoride levels they were exposed to at younger ages when bones were growing. (The Bassin et al. study was subsequently published.[116]) The National Research Council report describes this study as having "important strengths and major deficits"[117]. A follow-up study from the same department at Harvard was expected to be published several years ago, but is not yet available.

The National Research Council report outlines a few other studies related to cancers of interest such as kidney, bladder, oral-pharyngeal and uterine[118], the results of which are generally inconclusive. Overall, the National Research Council report concluded with regard to the epidemiological studies in people that "the combined literature described above does not clearly indicate that fluoride either is or is not carcinogenic in humans"[119]. Weighing all the cancer information, the report concluded that "On the basis of the committee's collective consideration of data from humans, genotoxicity assays, and studies of mechanisms of action in cell systems (e.g., bone cells in vitro) the evidence on the potential of fluoride to initiate or promote cancers, particularly of the bone, is tentative and mixed."[120]

Context

Other reviews of cancer data state the following:

- York University, United Kingdom, 2000: "There is no clear association between water fluoridation and overall cancer incidence and mortality. This was also true for osteosarcoma and bone/joint cancers."[121] It should be noted that this review was based on 26 studies, although 18 were noted to be the lowest level of evidence with the most risk of bias. The review was published before the result of the Bassin et al. study was available.

- Health Canada, 2009: "According to the findings and recommendations from the Expert Panel Meeting on fluoride held recently in Canada (Health Canada, 2008), the weight of scientific evidence does not support a link between fluoride and cancer."[122]

- European Commission, 2010: "SCHER *(Scientific Committee on Health and Environmental Risks)* agrees that some epidemiologic studies seem to indicate a possible link between fluoride in drinking water and osteosarcoma, but the studies are equivocal. There is no evidence from animal studies to support the link, and thus fluoride cannot be classified as to its carcinogenicity."[123]

Osteosarcoma is a rare cancer that occurs at a rate of approximately 3 per million people in the United States[124]. It can affect children and adolescents less than 20 years of age, and is slightly more common in males than females. In Middlesex-London, there is approximately one case of bone and joint cancer (a larger category that includes osteosarcoma) per year in those less than 20 years of age in males and females combined[125]. If an association exists between fluoride and osteosarcoma, the inconsistencies in the results of the studies would indicate that the risk is small.

D.8 Summary of fluoride and specific body systems

The National Research Council report stated that "In light of the collective evidence on various health end points and total exposure to fluoride, the committee concludes that the EPA's MCLG *(Environmental Protection Agency's Maximum Contaminant Level Goal)* of 4 mg/L should be lowered."[126] The Committee did not make any recommendations with regard to the secondary maximum contaminant level of 2 mg/L.[127]

Table 3 provides a brief overview of the general findings from the National Research Council report and the information provided in this document to add context.

Table 3: Overview based on the general findings of the National Research Council report and information provided to add context to the findings

Body System		Overview
Teeth		Severe fluorosis does not occur at fluoride levels less than 2 mg/L of fluoride in drinking water; Moderate fluorosis occurs in less than 15% of people at 2 mg/L of fluoride in drinking water; ***Context*** No severe and almost no moderate fluorosis were found in Canada. Mild and very mild fluorosis were found in 4% and 12% respectively of children 6-12 years of age.
Musculoskeletal (Bones and Joints)	**Fracture**	Lifetime exposure to fluoride at drinking water concentrations of 4 mg/L is likely to increase fracture rates in the population, compared with exposure to fluoride at 1 mg/L, particularly in some subgroups of people such as those with renal disease; Fracture risk at 2 mg/L of fluoride is suggestive but inadequate to draw conclusions; The totality of studies on fluoride in drinking water at approximately 1.0 mg/L indicates no effect on fractures.
	Skeletal fluorosis	Stage III skeletal fluorosis is rare in the United States. Stage II skeletal fluorosis is also a health concern but rates in the United States are unknown at 4 mg/L of fluoride in drinking water. ***Context*** Based on estimates of fluoride exposure levels likely to cause fluorosis, this outcome would be very unusual at low levels of fluoride in fluoridated drinking water.
	Arthritis	Likely to be no effect of fluoride on arthritis at environmental doses.
Reproductive and developmental (Down's syndrome)	**Reproductive**	Animal studies show reproductive and developmental effects only at very high levels of fluoride; The few studies done in humans have significant shortcomings in design and power, limiting inferences.
	Down's syndrome	The few Down's syndrome studies are of poor quality and the results are inconclusive making them of little value for risk evaluation.

Body System		Overview
Neurotoxicity and neurobehavioral (IQ)		Studies comparing villages in China found lower IQs in villages with higher fluoride levels; Animal studies found effects on the behaviour of animals at high levels of fluoride exposure; some of the studies used different methods than commonly used by researchers. ***Context*** IQ studies considered to have problems with how they were conducted; Studies of IQ in humans involved higher levels of fluoride exposure and have been conducted in developing countries where nutritional, educational, income and environmental factors differ from developed countries.
Endocrine (thyroid, thyroid parafollicular cells, parathyroid, pineal gland, glucose intolerance)	**Thyroid**	Some studies suggest that abnormal thyroid function and/or goitre may be associated with higher levels of fluoride, particularly when iodine levels are low. ***Context*** Studies suggesting an association between fluoride and thyroid were conducted in developing countries with other potential nutritional factors and environmental exposures that may influence the results.
	Parathyroid	High levels of fluoride may have an impact on calcium and/or parathyroid function.
	Thyroid parafollicular, pineal gland, glucose intolerance	Few studies presented.
Gastrointestinal, renal (kidney), hepatic (liver) and immune system	**Gastrointestinal**	Gastrointestinal effects can occur at high levels of fluoride.
	Kidney	Effects of fluoride on kidney stones mixed between promoting stones and protecting against stones. High levels of fluoride may cause adverse effects on the kidney. No studies show effects on the kidneys at low levels of fluoride.
	Liver	Available data insufficient to draw conclusions about low-level, long-term fluoride exposure.
	Immune system	The effect of 4 mg/L of fluoride in drinking water has not been studied in humans and the effect of fluoride on people with immunodeficiencies has also not been assessed.
Genotoxicity and carcinogenicity (cancer)	**Genotoxicity**	Inconsistent findings make evaluation difficult.
	Cancer	Cancer studies mainly focused on osteosarcoma; some studies have suggested an association between fluoride and osteosarcoma in young men while other studies have not.

E. CONCLUSIONS

The National Research Council report is intended to assess the safety of levels of naturally-occurring fluoride between 2 and 4 mg/L in drinking water in the United States. The report provides a review of both animal and human data related to possible effects of fluoride on many systems of the body with a focus on research conducted since1993.

Because the National Research Council report is intended to address the effects of fluoride at levels between 2 and 4 mg/L, it often does not allow conclusions to be drawn regarding lower levels of fluoride exposure. In general, the animal studies reviewed in the National Research Council report involved using doses of fluoride well above those that would be encountered in London and any findings at these levels of exposure likely have little applicability to London's drinking water. Many of the studies in humans also assess higher levels of fluoride exposure than would be experienced from London's drinking water. These studies include: people whose drinking water has high levels of naturally-occurring fluoride levels; people exposed to fluoride in air from cooking sources; workers exposed to fluoride occupationally; people who took high doses of fluoride as part of studies to assess its potential effects on treating osteoporosis, and people who were given fluorinated anaesthetic agents. It also should be noted that studies of high naturally-occurring levels of fluoride were often done in small communities in developing countries such as villages in China. Many factors differ between these developing countries and developed countries, including nutrition, other environmental exposures, education and income; therefore, studies from developing countries have questionable applicability to developed settings such as London.

Human research into possible causal mechanisms is pursued based on clinical observations, the understanding of biologic mechanisms and animal research. Considerable research has been done into the causes of cancer, diabetes and thyroid disease. Possible associations between cancer and fluoride have been studied in the past, however, low levels of fluoride exposure have not been identified as an area for major research in relation to diabetes or thyroid disease.

Large effects are generally easy to identify, therefore, if fluoride had a large impact on diseases such as osteosarcoma these effects should be easy to detect and replicate. Large effects may be apparent based on clinical observations alone. Even studies with poor designs and inherent weaknesses may find large effects. Smaller effects are more difficult to determine and require more studies with better designs and higher quality implementation. The National Research Council report identifies the need for additional research in several areas.

Years of widespread use of low levels of fluoride and the totality of the evidence of low-level exposures to fluoride do not indicate significant health concerns associated with its use. Careful attention to limiting exposure to fluoridated toothpaste when teeth are developing will help ensure no severe or moderate fluorosis and low rates of mild and very mild fluorosis, which are the only adverse effect proven to occur at low levels of fluoride exposure.

The final version of the Health Canada report on fluoride is expected shortly. It will assess the Maximum Acceptable Concentration (MAC) for fluoride in drinking water in Canada (1.5 mg/L) and will provide an additional systematic review of the effects of fluoride in drinking water.

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FLUORIDE IN DRINKING WATER

A SCIENTIFIC REVIEW OF EPA'S STANDARDS

Committee on Fluoride in Drinking Water

Board on Environmental Studies and Toxicology

Division on Earth and Life Studies

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Summary

Under the Safe Drinking Water Act, the U.S. Environmental Protection Agency (EPA) is required to establish exposure standards for contaminants in public drinking-water systems that might cause any adverse effects on human health. These standards include the maximum contaminant level goal (MCLG), the maximum contaminant level (MCL), and the secondary maximum contaminant level (SMCL). The MCLG is a health goal set at a concentration at which no adverse health effects are expected to occur and the margins of safety are judged "adequate." The MCL is the enforceable standard that is set as close to the MCLG as possible, taking into consideration other factors, such as treatment technology and costs. For some contaminants, EPA also establishes an SMCL, which is a guideline for managing drinking water for aesthetic, cosmetic, or technical effects.

Fluoride is one of the drinking-water contaminants regulated by EPA. In 1986, EPA established an MCLG and MCL for fluoride at a concentration of 4 milligrams per liter (mg/L) and an SMCL of 2 mg/L. These guidelines are restrictions on the total amount of fluoride allowed in drinking water. Because fluoride is well known for its use in the prevention of dental caries, it is important to make the distinction here that EPA's drinking-water guidelines are not recommendations about adding fluoride to drinking water to protect the public from dental caries. Guidelines for that purpose (0.7 to 1.2 mg/L) were established by the U.S. Public Health Service more than 40 years ago. Instead, EPA's guidelines are maximum allowable concentrations in drinking water intended to prevent toxic or other adverse effects that could result from exposure to fluoride.

In the early 1990s at the request of EPA, the National Research Council

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(NRC) independently reviewed the health effects of ingested fluoride and the scientific basis for EPA's MCL. It concluded that the MCL was an appropriate interim standard but that further research was needed to fill data gaps on total exposure to fluoride and its toxicity. Because new research on fluoride is now available and because the Safe Drinking Water Act requires periodic reassessment of regulations for drinking-water contaminants, EPA requested that the NRC again evaluate the adequacy of its MCLG and SMCL for fluoride to protect public health.

COMMITTEE'S TASK

In response to EPA's request, the NRC convened the Committee on Fluoride in Drinking Water, which prepared this report. The committee was charged to review toxicologic, epidemiologic, and clinical data on fluoride—particularly data published since the NRC's previous (1993) report—and exposure data on orally ingested fluoride from drinking water and other sources. On the basis of its review, the committee was asked to evaluate independently the scientific basis of EPA's MCLG of 4 mg/L and SMCL of 2 mg/L in drinking water and the adequacy of those guidelines to protect children and others from adverse health effects. The committee was asked to consider the relative contribution of various fluoride sources (e.g., drinking water, food, dental-hygiene products) to total exposure. The committee was also asked to identify data gaps and to make recommendations for future research relevant to setting the MCLG and SMCL for fluoride. Addressing questions of artificial fluoridation, economics, risk-benefit assessment, and water-treatment technology was not part of the committee's charge.

THE COMMITTEE'S EVALUATION

To accomplish its task, the committee reviewed a large body of research on fluoride, focusing primarily on studies generated since the early 1990s, including information on exposure; pharmacokinetics; adverse effects on various organ systems; and genotoxic and carcinogenic potential. The collective evidence from in vitro assays, animal research, human studies, and mechanistic information was used to assess whether multiple lines of evidence indicate human health risks. The committee only considered adverse effects that might result from exposure to fluoride; it did not evaluate health risk from lack of exposure to fluoride or fluoride's efficacy in preventing dental caries.

After reviewing the collective evidence, including studies conducted since the early 1990s, the committee concluded unanimously that the present MCLG of 4 mg/L for fluoride should be lowered. Exposure at the MCLG clearly puts children at risk of developing severe enamel fluorosis,

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a condition that is associated with enamel loss and pitting. In addition, the majority of the committee concluded that the MCLG is not likely to be protective against bone fractures. The basis for these conclusions is expanded upon below.

Exposure to Fluoride

The major sources of exposure to fluoride are drinking water, food, dental products, and pesticides. The biggest contributor to exposure for most people in the United States is drinking water. Estimates from 1992 indicate that approximately 1.4 million people in the United States had drinking water with natural fluoride concentrations of 2.0-3.9 mg/L, and just over 200,000 people had concentrations equal to or exceeding 4 mg/L (the presented MCL). In 2000, it was estimated that approximately 162 million people had artificially fluoridated water (0.7-1.2 mg/L).

Food sources contain various concentrations of fluoride and are the second largest contributor to exposure. Beverages contribute most to estimated fluoride intake, even when excluding contributions from local tap water. The greatest source of nondietary fluoride is dental products, primarily toothpastes. The public is also exposed to fluoride from background air and from certain pesticide residues. Other sources include certain pharmaceuticals and consumer products.

Highly exposed subpopulations include individuals who have high concentrations of fluoride in drinking water, who drink unusually large volumes of water, or who are exposed to other important sources of fluoride. Some subpopulations consume much greater quantities of water than the 2 L per day that EPA assumes for adults, including outdoor workers, athletes, and people with certain medical conditions, such as diabetes insipidus. On a per-body-weight basis, infants and young children have approximately three to four times greater exposure than do adults. Dental-care products are also a special consideration for children, because many tend to use more toothpaste than is advised, their swallowing control is not as well developed as that of adults, and many children under the care of a dentist undergo fluoride treatments.

Overall, the committee found that the contribution to total fluoride exposure from fluoride in drinking water in the average person, depending on age, is 57% to 90% at 2 mg/L and 72% to 94% at 4 mg/L. For high-water-intake individuals, the drinking-water contribution is 86% to 96% at 2 mg/L and 92% to 98% at 4 mg/L. Among individuals with an average water-intake rate, infants and children have the greatest total exposure to fluoride, ranging from 0.079 to 0.258 mg/kg/day at 4 mg/L and 0.046 to 0.144 mg/kg/day at 2 mg/L in drinking water. For high-water-intake individuals exposed to fluoride at 4 mg/L, total exposure ranges from 0.294

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mg/kg/day for adults to 0.634 mg/kg/day for children. The corresponding intake range at 2 mg/L is 0.154 to 0.334 mg/kg/day for adults and children, respectively.

Dental Effects

Enamel fluorosis is a dose-related mottling of enamel that can range from mild discoloration of the tooth surface to severe staining and pitting. The condition is permanent after it develops in children during tooth formation, a period ranging from birth until about the age of 8. Whether to consider enamel fluorosis, particularly the moderate to severe forms, to be an adverse health effect or a cosmetic effect has been the subject of debate for decades. In previous assessments, all forms of enamel fluorosis, including the severest form, have been judged to be aesthetically displeasing but not adverse to health. This view has been based largely on the absence of direct evidence that severe enamel fluorosis results in tooth loss; loss of tooth function; or psychological, behavioral, or social problems.

Severe enamel fluorosis is characterized by dark yellow to brown staining and discrete and confluent pitting, which constitutes enamel loss. The committee finds the rationale for considering severe enamel fluorosis only a cosmetic effect to be much weaker for discrete and confluent pitting than for staining. One of the functions of tooth enamel is to protect the dentin and, ultimately, the pulp from decay and infection. Severe enamel fluorosis compromises that health-protective function by causing structural damage to the tooth. The damage to teeth caused by severe enamel fluorosis is a toxic effect that is consistent with prevailing risk assessment definitions of adverse health effects. This view is supported by the clinical practice of filling enamel pits in patients with severe enamel fluorosis and restoring the affected teeth. Moreover, the plausible hypothesis concerning elevated frequency of caries in persons with severe enamel fluorosis has been accepted by some authorities, and the available evidence is mixed but generally supportive.

Severe enamel fluorosis occurs at an appreciable frequency, approximately 10% on average, among children in U.S. communities with water fluoride concentrations at or near the current MCLG of 4 mg/L. Thus, the MCLG is not adequately protective against this condition.

Two of the 12 members of the committee did not agree that severe enamel fluorosis should now be considered an adverse health effect. They agreed that it is an adverse dental effect but found that no new evidence has emerged to suggest a link between severe enamel fluorosis, as experienced in the United States, and a person's ability to function. They judged that demonstration of enamel defects alone from fluorosis is not sufficient to change the prevailing opinion that severe enamel fluorosis is an adverse cosmetic effect. Despite their disagreement on characterization of the condition, these

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two members concurred with the committee's conclusion that the MCLG should prevent the occurrence of this unwanted condition.

Enamel fluorosis is also of concern from an aesthetic standpoint because it discolors or results in staining of teeth. No data indicate that staining alone affects tooth function or susceptibility to caries, but a few studies have shown that tooth mottling affects aesthetic perception of facial attractiveness. It is difficult to draw conclusions from these studies, largely because perception of the condition and facial attractiveness are subjective and culturally influenced. The committee finds that it is reasonable to assume that some individuals will find *moderate* enamel fluorosis on front teeth to be detrimental to their appearance and that it could affect their overall sense of well-being. However, the available data are not adequate to categorize moderate enamel fluorosis as an adverse health effect on the basis of structural or psychological effects.

Since 1993, there have been no new studies of enamel fluorosis in U.S. communities with fluoride at 2 mg/L in drinking water. Earlier studies indicated that the prevalence of moderate enamel fluorosis at that concentration could be as high as 15%. Because enamel fluorosis has different distribution patterns among teeth, depending on when exposure occurred during tooth development and on enamel thickness, and because current indexes for categorizing enamel fluorosis do not differentiate between mottling of anterior and posterior teeth, the committee was not able to determine what percentage of moderate cases might be of cosmetic concern.

Musculoskeletal Effects

Concerns about fluoride's effects on the musculoskeletal system historically have been and continue to be focused on skeletal fluorosis and bone fracture. Fluoride is readily incorporated into the crystalline structure of bone and will accumulate over time. Since the previous 1993 NRC review of fluoride, two pharmacokinetic models were developed to predict bone concentrations from chronic exposure to fluoride. Predictions based on these models were used in the committee's assessments below.

Skeletal Fluorosis

Skeletal fluorosis is a bone and joint condition associated with prolonged exposure to high concentrations of fluoride. Fluoride increases bone density and appears to exacerbate the growth of osteophytes present in the bone and joints, resulting in joint stiffness and pain. The condition is categorized into one of four stages: a preclinical stage and three clinical stages that increase in severity. The most severe stage (clinical stage III) historically has been referred to as the "crippling" stage. At stage II, mobility is not significantly

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affected, but it is characterized by chronic joint pain, arthritic symptoms, slight calcification of ligaments, and osteosclerosis of the cancellous bones. Whether EPA's MCLG of 4 mg/L protects against these precursors to more serious mobility problems is unclear.

Few clinical cases of skeletal fluorosis in healthy U.S. populations have been reported in recent decades, and the committee did not find any recent studies to evaluate the prevalence of the condition in populations exposed to fluoride at the MCLG. Thus, to answer the question of whether EPA's MCLG protects the general public from stage II and stage III skeletal fluorosis, the committee compared pharmacokinetic model predictions of bone fluoride concentrations and historical data on iliac-crest bone fluoride concentrations associated with the different stages of skeletal fluorosis. The models estimated that bone fluoride concentrations resulting from lifetime exposure to fluoride in drinking water at 2 mg/L (4,000 to 5,000 mg/kg ash) or 4 mg/L (10,000 to 12,000 mg/kg ash) fall within or exceed the ranges historically associated with stage II and stage III skeletal fluorosis (4,300 to 9,200 mg/kg ash and 4,200 to 12,700 mg/kg ash, respectively). However, this comparison alone is insufficient for determining whether stage II or III skeletal fluorosis is a risk for populations exposed to fluoride at 4 mg/L, because bone fluoride concentrations and the levels at which skeletal fluorosis occurs vary widely. On the basis of the existing epidemiologic literature, stage III skeletal fluorosis appears to be a rare condition in the United Sates; furthermore, the committee could not determine whether stage II skeletal fluorosis is occurring in U.S. residents who drink water with fluoride at 4 mg/L. Thus, more research is needed to clarify the relationship between fluoride ingestion, fluoride concentrations in bone, and stage of skeletal fluorosis before any conclusions can be drawn.

Bone Fractures

Several epidemiologic studies of fluoride and bone fractures have been published since the 1993 NRC review. The committee focused its review on observational studies of populations exposed to drinking water containing fluoride at 2 to 4 mg/L or greater and on clinical trials of fluoride (20-34 mg/day) as a treatment for osteoporosis. Several strong observational studies indicated an increased risk of bone fracture in populations exposed to fluoride at 4 mg/L, and the results of other studies were qualitatively consistent with that finding. The one study using serum fluoride concentrations found no appreciable relationship to fractures. Because serum fluoride concentrations may not be a good measure of bone fluoride concentrations or long-term exposure, the ability to show an association might have been diminished in that study. A meta-analysis of randomized clinical trials reported an elevated risk of new nonvertebral fractures and a slightly decreased risk of vertebral

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fractures after 4 years of fluoride treatment. An increased risk of bone fracture was found among a subset of the trials that the committee found most informative for assessing long-term exposure. Although the duration and concentrations of exposure to fluoride differed between the observational studies and the clinical trials, bone fluoride content was similar (6,200 to more than 11,000 mg/kg ash in observational studies and 5,400 to 12,000 mg/kg ash in clinical trials).

Fracture risk and bone strength have been studied in animal models. The weight of evidence indicates that, although fluoride might increase bone volume, there is less strength per unit volume. Studies of rats indicate that bone strength begins to decline when fluoride in bone ash reaches 6,000 to 7,000 mg/kg. However, more research is needed to address uncertainties associated with extrapolating data on bone strength and fractures from animals to humans. Important species differences in fluoride uptake, bone remodeling, and growth must be considered. Biochemical and physiological data indicate a biologically plausible mechanism by which fluoride could weaken bone. In this case, the physiological effect of fluoride on bone quality and risk of fracture observed in animal studies is consistent with the human evidence.

Overall, there was consensus among the committee that there is scientific evidence that under certain conditions fluoride can weaken bone and increase the risk of fractures. The majority of the committee concluded that lifetime exposure to fluoride at drinking-water concentrations of 4 mg/L or higher is likely to increase fracture rates in the population, compared with exposure to 1 mg/L, particularly in some demographic subgroups that are prone to accumulate fluoride into their bones (e.g., people with renal disease). However, 3 of the 12 members judged that the evidence only supports a conclusion that the MCLG *might not* be protective against bone fracture. Those members judged that more evidence is needed to conclude that bone fractures occur at an appreciable frequency in human populations exposed to fluoride at 4 mg/L and that the MCLG is not *likely* to be protective.

There were few studies to assess fracture risk in populations exposed to fluoride at 2 mg/L in drinking water. The best available study, from Finland, suggested an increased rate of hip fracture in populations exposed to fluoride at concentrations above 1.5 mg/L. However, this study alone is not sufficient to judge fracture risk for people exposed to fluoride at 2 mg/L. Thus, no conclusions could be drawn about fracture risk or safety at 2 mg/L.

Reproductive and Developmental Effects

A large number of reproductive and developmental studies in animals have been conducted and published since the 1993 NRC report, and the

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overall quality of that database has improved significantly. Those studies indicated that adverse reproductive and developmental outcomes occur only at very high concentrations that are unlikely to be encountered by U.S. populations. A few human studies suggested that high concentrations of fluoride exposure might be associated with alterations in reproductive hormones, effects on fertility, and developmental outcomes, but design limitations make those studies insufficient for risk evaluation.

Neurotoxicity and Neurobehavioral Effects

Animal and human studies of fluoride have been published reporting adverse cognitive and behavioral effects. A few epidemiologic studies of Chinese populations have reported IQ deficits in children exposed to fluoride at 2.5 to 4 mg/L in drinking water. Although the studies lacked sufficient detail for the committee to fully assess their quality and relevance to U.S. populations, the consistency of the results appears significant enough to warrant additional research on the effects of fluoride on intelligence.

A few animal studies have reported alterations in the behavior of rodents after treatment with fluoride, but the committee did not find the changes to be substantial in magnitude. More compelling were studies on molecular, cellular, and anatomical changes in the nervous system found after fluoride exposure, suggesting that functional changes could occur. These changes might be subtle or seen only under certain physiological or environmental conditions. More research is needed to clarify the effect of fluoride on brain chemistry and function.

Endocrine Effects

The chief endocrine effects of fluoride exposures in experimental animals and in humans include decreased thyroid function, increased calcitonin activity, increased parathyroid hormone activity, secondary hyperparathyroidism, impaired glucose tolerance, and possible effects on timing of sexual maturity. Some of these effects are associated with fluoride intake that is achievable at fluoride concentrations in drinking water of 4 mg/L or less, especially for young children or for individuals with high water intake. Many of the effects could be considered subclinical effects, meaning that they are not adverse health effects. However, recent work on borderline hormonal imbalances and endocrine-disrupting chemicals indicated that adverse health effects, or increased risks for developing adverse effects, might be associated with seemingly mild imbalances or perturbations in hormone concentrations. Further research is needed to explore these possibilities.

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Effects on Other Organ Systems

The committee also considered effects on the gastrointestinal system, kidneys, liver, and immune system. There were no human studies on drinking water containing fluoride at 4 mg/L in which gastrointestinal, renal, hepatic, or immune effects were carefully documented. Case reports and in vitro and animal studies indicated that exposure to fluoride at concentrations greater than 4 mg/L can be irritating to the gastrointestinal system, affect renal tissues and function, and alter hepatic and immunologic parameters. Such effects are unlikely to be a risk for the average individual exposed to fluoride at 4 mg/L in drinking water. However, a potentially susceptible subpopulation comprises individuals with renal impairments who retain more fluoride than healthy people do.

Genotoxicity and Carcinogenicity

Many assays have been performed to assess the genotoxicity of fluoride. Since the 1993 NRC review, the most significant additions to the database are in vivo assays in human populations and, to a lesser extent, in vitro assays with human cell lines and in vivo experiments with rodents. The results of the in vivo human studies are mixed. The results of in vitro tests are also conflicting and do not contribute significantly to the interpretation of the existing database. Evidence on the cytogenetic effects of fluoride at environmental concentrations is contradictory.

Whether fluoride might be associated with bone cancer has been a subject of debate. Bone is the most plausible site for cancer associated with fluoride because of its deposition into bone and its mitogenic effects on bone cells in culture. In a 1990 cancer bioassay, the overall incidence of osteosarcoma in male rats exposed to different amounts of fluoride in drinking water showed a positive dose-response trend. In a 1992 study, no increase in osteosarcoma was reported in male rats, but most of the committee judged the study to have insufficient power to counter the evidence for the trend found in the 1990 bioassay.

Several epidemiologic investigations of the relation between fluoride and cancer have been performed since the 1993 evaluation, including both individual-based and ecologic studies. Several studies had significant methodological limitations that made it difficult to draw conclusions. Overall, the results are mixed, with some studies reporting a positive association and others no association.

On the basis of the committee's collective consideration of data from humans, genotoxicity assays, and studies of mechanisms of action in cell systems (e.g., bone cells in vitro), the evidence on the potential of fluoride to initiate or promote cancers, particularly of the bone, is tentative and

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mixed. Assessing whether fluoride constitutes a risk factor for osteosarcoma is complicated by the rarity of the disease and the difficulty of characterizing biologic dose because of the ubiquity of population exposure to fluoride and the difficulty of acquiring bone samples in nonaffected individuals.

A relatively large hospital-based case-control study of osteosarcoma and fluoride exposure is under way at the Harvard School of Dental Medicine and is expected to be published in 2006. That study will be an important addition to the fluoride database, because it will have exposure information on residence histories, water consumption, and assays of bone and toenails. The results of that study should help to identify what future research will be most useful in elucidating fluoride's carcinogenic potential.

DRINKING-WATER STANDARDS

Maximum-Contaminant-Level Goal

In light of the collective evidence on various health end points and total exposure to fluoride, the committee concludes that EPA's MCLG of 4 mg/L should be lowered. Lowering the MCLG will prevent children from developing severe enamel fluorosis and will reduce the lifetime accumulation of fluoride into bone that the majority of the committee concludes is likely to put individuals at increased risk of bone fracture and possibly skeletal fluorosis, which are particular concerns for subpopulations that are prone to accumulating fluoride in their bones.

To develop an MCLG that is protective against severe enamel fluorosis, clinical stage II skeletal fluorosis, and bone fractures, EPA should update the risk assessment of fluoride to include new data on health risks and better estimates of total exposure (relative source contribution) for individuals. EPA should use current approaches for quantifying risk, considering susceptible subpopulations, and characterizing uncertainties and variability.

Secondary Maximum Contaminant Level

The prevalence of severe enamel fluorosis is very low (near zero) at fluoride concentrations below 2 mg/L. From a cosmetic standpoint, the SMCL does not completely prevent the occurrence of moderate enamel fluorosis. EPA has indicated that the SMCL was intended to reduce the severity and occurrence of the condition to 15% or less of the exposed population. The available data indicate that fewer than 15% of children will experience moderate enamel fluorosis of aesthetic concern (discoloration of the front teeth) at that concentration. However, the degree to which moderate enamel fluorosis might go beyond a cosmetic effect to create an adverse psychological effect or an adverse effect on social functioning is not known.

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OTHER PUBLIC HEALTH ISSUES

The committee's conclusions regarding the potential for adverse effects from fluoride at 2 to 4 mg/L in drinking water do not address the lower exposures commonly experienced by most U.S. citizens. Fluoridation is widely practiced in the United States to protect against the development of dental caries; fluoride is added to public water supplies at 0.7 to 1.2 mg/L. The charge to the committee did not include an examination of the benefits and risks that might occur at these lower concentrations of fluoride in drinking water.

RESEARCH NEEDS

As noted above, gaps in the information on fluoride prevented the committee from making some judgments about the safety or the risks of fluoride at concentrations of 2 to 4 mg/L. The following research will be useful for filling those gaps and guiding revisions to the MCLG and SMCL for fluoride.

- Exposure assessment

— Improved assessment of exposure to fluoride from all sources is needed for a variety of populations (e.g., different socioeconomic conditions). To the extent possible, exposures should be characterized for individuals rather than communities, and epidemiologic studies should group individuals by exposure level rather than by source of exposure, location of residence, or fluoride concentration in drinking water. Intakes or exposures should be characterized with and without normalization for body weight. Fluoride should be included in nationwide biomonitoring surveys and nutritional studies; in particular, analysis of fluoride in blood and urine samples taken in these surveys would be valuable.

- Pharmacokinetic studies

— The concentrations of fluoride in human bone as a function of exposure concentration, exposure duration, age, sex, and health status should be studied. Such studies would be greatly aided by noninvasive means of measuring bone fluoride. Information is particularly needed on fluoride plasma and bone concentrations in people with small-to-moderate changes in renal function as well as in those with serious renal deficiency.

— Improved and readily available pharmacokinetic models should be developed. Additional cross-species pharmacokinetic comparisons would help to validate such models.

- Studies of enamel fluorosis

— Additional studies, including longitudinal studies, should be done in U.S. communities with water fluoride concentrations greater than 1 mg/L.

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These studies should focus on moderate and severe enamel fluorosis in relation to caries and in relation to psychological, behavioral, and social effects among affected children, their parents, and affected children after they become adults.

— Methods should be developed and validated to objectively assess enamel fluorosis. Consideration should be given to distinguishing between staining or mottling of the anterior teeth and of the posterior teeth so that aesthetic consequences can be more easily assessed.

— More research is needed on the relation between fluoride exposure and dentin fluorosis and delayed tooth eruption patterns.

- Bone studies

— A systematic study of clinical stage II and stage III skeletal fluorosis should be conducted to clarify the relationship between fluoride ingestion, fluoride concentration in bone, and clinical symptoms.

— More studies of communities with drinking water containing fluoride at 2 mg/L or more are needed to assess potential bone fracture risk at these higher concentrations. Quantitative measures of fracture, such as radiologic assessment of vertebral body collapse, should be used instead of self-reported fractures or hospital records. Moreover, if possible, bone fluoride concentrations should be measured in long-term residents.

- Other health effects

— Carefully conducted studies of exposure to fluoride and emerging health parameters of interest (e.g., endocrine effects and brain function) should be performed in populations in the United States exposed to various concentrations of fluoride. It is important that exposures be appropriately documented.

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FLUORIDE IN DRINKING WATER

A SCIENTIFIC REVIEW OF EPA'S STANDARDS

Committee on Fluoride in Drinking Water

Board on Environmental Studies and Toxicology

Division on Earth and Life Studies

NATIONAL RESEARCH COUNCIL
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Summary

Under the Safe Drinking Water Act, the U.S. Environmental Protection Agency (EPA) is required to establish exposure standards for contaminants in public drinking-water systems that might cause any adverse effects on human health. These standards include the maximum contaminant level goal (MCLG), the maximum contaminant level (MCL), and the secondary maximum contaminant level (SMCL). The MCLG is a health goal set at a concentration at which no adverse health effects are expected to occur and the margins of safety are judged "adequate." The MCL is the enforceable standard that is set as close to the MCLG as possible, taking into consideration other factors, such as treatment technology and costs. For some contaminants, EPA also establishes an SMCL, which is a guideline for managing drinking water for aesthetic, cosmetic, or technical effects.

Fluoride is one of the drinking-water contaminants regulated by EPA. In 1986, EPA established an MCLG and MCL for fluoride at a concentration of 4 milligrams per liter (mg/L) and an SMCL of 2 mg/L. These guidelines are restrictions on the total amount of fluoride allowed in drinking water. Because fluoride is well known for its use in the prevention of dental caries, it is important to make the distinction here that EPA's drinking-water guidelines are not recommendations about adding fluoride to drinking water to protect the public from dental caries. Guidelines for that purpose (0.7 to 1.2 mg/L) were established by the U.S. Public Health Service more than 40 years ago. Instead, EPA's guidelines are maximum allowable concentrations in drinking water intended to prevent toxic or other adverse effects that could result from exposure to fluoride.

In the early 1990s at the request of EPA, the National Research Council

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(NRC) independently reviewed the health effects of ingested fluoride and the scientific basis for EPA's MCL. It concluded that the MCL was an appropriate interim standard but that further research was needed to fill data gaps on total exposure to fluoride and its toxicity. Because new research on fluoride is now available and because the Safe Drinking Water Act requires periodic reassessment of regulations for drinking-water contaminants, EPA requested that the NRC again evaluate the adequacy of its MCLG and SMCL for fluoride to protect public health.

COMMITTEE'S TASK

In response to EPA's request, the NRC convened the Committee on Fluoride in Drinking Water, which prepared this report. The committee was charged to review toxicologic, epidemiologic, and clinical data on fluoride—particularly data published since the NRC's previous (1993) report—and exposure data on orally ingested fluoride from drinking water and other sources. On the basis of its review, the committee was asked to evaluate independently the scientific basis of EPA's MCLG of 4 mg/L and SMCL of 2 mg/L in drinking water and the adequacy of those guidelines to protect children and others from adverse health effects. The committee was asked to consider the relative contribution of various fluoride sources (e.g., drinking water, food, dental-hygiene products) to total exposure. The committee was also asked to identify data gaps and to make recommendations for future research relevant to setting the MCLG and SMCL for fluoride. Addressing questions of artificial fluoridation, economics, risk-benefit assessment, and water-treatment technology was not part of the committee's charge.

THE COMMITTEE'S EVALUATION

To accomplish its task, the committee reviewed a large body of research on fluoride, focusing primarily on studies generated since the early 1990s, including information on exposure; pharmacokinetics; adverse effects on various organ systems; and genotoxic and carcinogenic potential. The collective evidence from in vitro assays, animal research, human studies, and mechanistic information was used to assess whether multiple lines of evidence indicate human health risks. The committee only considered adverse effects that might result from exposure to fluoride; it did not evaluate health risk from lack of exposure to fluoride or fluoride's efficacy in preventing dental caries.

After reviewing the collective evidence, including studies conducted since the early 1990s, the committee concluded unanimously that the present MCLG of 4 mg/L for fluoride should be lowered. Exposure at the MCLG clearly puts children at risk of developing severe enamel fluorosis,

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a condition that is associated with enamel loss and pitting. In addition, the majority of the committee concluded that the MCLG is not likely to be protective against bone fractures. The basis for these conclusions is expanded upon below.

Exposure to Fluoride

The major sources of exposure to fluoride are drinking water, food, dental products, and pesticides. The biggest contributor to exposure for most people in the United States is drinking water. Estimates from 1992 indicate that approximately 1.4 million people in the United States had drinking water with natural fluoride concentrations of 2.0-3.9 mg/L, and just over 200,000 people had concentrations equal to or exceeding 4 mg/L (the presented MCL). In 2000, it was estimated that approximately 162 million people had artificially fluoridated water (0.7-1.2 mg/L).

Food sources contain various concentrations of fluoride and are the second largest contributor to exposure. Beverages contribute most to estimated fluoride intake, even when excluding contributions from local tap water. The greatest source of nondietary fluoride is dental products, primarily toothpastes. The public is also exposed to fluoride from background air and from certain pesticide residues. Other sources include certain pharmaceuticals and consumer products.

Highly exposed subpopulations include individuals who have high concentrations of fluoride in drinking water, who drink unusually large volumes of water, or who are exposed to other important sources of fluoride. Some subpopulations consume much greater quantities of water than the 2 L per day that EPA assumes for adults, including outdoor workers, athletes, and people with certain medical conditions, such as diabetes insipidus. On a per-body-weight basis, infants and young children have approximately three to four times greater exposure than do adults. Dental-care products are also a special consideration for children, because many tend to use more toothpaste than is advised, their swallowing control is not as well developed as that of adults, and many children under the care of a dentist undergo fluoride treatments.

Overall, the committee found that the contribution to total fluoride exposure from fluoride in drinking water in the average person, depending on age, is 57% to 90% at 2 mg/L and 72% to 94% at 4 mg/L. For high-water-intake individuals, the drinking-water contribution is 86% to 96% at 2 mg/L and 92% to 98% at 4 mg/L. Among individuals with an average water-intake rate, infants and children have the greatest total exposure to fluoride, ranging from 0.079 to 0.258 mg/kg/day at 4 mg/L and 0.046 to 0.144 mg/kg/day at 2 mg/L in drinking water. For high-water-intake individuals exposed to fluoride at 4 mg/L, total exposure ranges from 0.294

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mg/kg/day for adults to 0.634 mg/kg/day for children. The corresponding intake range at 2 mg/L is 0.154 to 0.334 mg/kg/day for adults and children, respectively.

Dental Effects

Enamel fluorosis is a dose-related mottling of enamel that can range from mild discoloration of the tooth surface to severe staining and pitting. The condition is permanent after it develops in children during tooth formation, a period ranging from birth until about the age of 8. Whether to consider enamel fluorosis, particularly the moderate to severe forms, to be an adverse health effect or a cosmetic effect has been the subject of debate for decades. In previous assessments, all forms of enamel fluorosis, including the severest form, have been judged to be aesthetically displeasing but not adverse to health. This view has been based largely on the absence of direct evidence that severe enamel fluorosis results in tooth loss; loss of tooth function; or psychological, behavioral, or social problems.

Severe enamel fluorosis is characterized by dark yellow to brown staining and discrete and confluent pitting, which constitutes enamel loss. The committee finds the rationale for considering severe enamel fluorosis only a cosmetic effect to be much weaker for discrete and confluent pitting than for staining. One of the functions of tooth enamel is to protect the dentin and, ultimately, the pulp from decay and infection. Severe enamel fluorosis compromises that health-protective function by causing structural damage to the tooth. The damage to teeth caused by severe enamel fluorosis is a toxic effect that is consistent with prevailing risk assessment definitions of adverse health effects. This view is supported by the clinical practice of filling enamel pits in patients with severe enamel fluorosis and restoring the affected teeth. Moreover, the plausible hypothesis concerning elevated frequency of caries in persons with severe enamel fluorosis has been accepted by some authorities, and the available evidence is mixed but generally supportive.

Severe enamel fluorosis occurs at an appreciable frequency, approximately 10% on average, among children in U.S. communities with water fluoride concentrations at or near the current MCLG of 4 mg/L. Thus, the MCLG is not adequately protective against this condition.

Two of the 12 members of the committee did not agree that severe enamel fluorosis should now be considered an adverse health effect. They agreed that it is an adverse dental effect but found that no new evidence has emerged to suggest a link between severe enamel fluorosis, as experienced in the United States, and a person's ability to function. They judged that demonstration of enamel defects alone from fluorosis is not sufficient to change the prevailing opinion that severe enamel fluorosis is an adverse cosmetic effect. Despite their disagreement on characterization of the condition, these

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two members concurred with the committee's conclusion that the MCLG should prevent the occurrence of this unwanted condition.

Enamel fluorosis is also of concern from an aesthetic standpoint because it discolors or results in staining of teeth. No data indicate that staining alone affects tooth function or susceptibility to caries, but a few studies have shown that tooth mottling affects aesthetic perception of facial attractiveness. It is difficult to draw conclusions from these studies, largely because perception of the condition and facial attractiveness are subjective and culturally influenced. The committee finds that it is reasonable to assume that some individuals will find *moderate* enamel fluorosis on front teeth to be detrimental to their appearance and that it could affect their overall sense of well-being. However, the available data are not adequate to categorize moderate enamel fluorosis as an adverse health effect on the basis of structural or psychological effects.

Since 1993, there have been no new studies of enamel fluorosis in U.S. communities with fluoride at 2 mg/L in drinking water. Earlier studies indicated that the prevalence of moderate enamel fluorosis at that concentration could be as high as 15%. Because enamel fluorosis has different distribution patterns among teeth, depending on when exposure occurred during tooth development and on enamel thickness, and because current indexes for categorizing enamel fluorosis do not differentiate between mottling of anterior and posterior teeth, the committee was not able to determine what percentage of moderate cases might be of cosmetic concern.

Musculoskeletal Effects

Concerns about fluoride's effects on the musculoskeletal system historically have been and continue to be focused on skeletal fluorosis and bone fracture. Fluoride is readily incorporated into the crystalline structure of bone and will accumulate over time. Since the previous 1993 NRC review of fluoride, two pharmacokinetic models were developed to predict bone concentrations from chronic exposure to fluoride. Predictions based on these models were used in the committee's assessments below.

Skeletal Fluorosis

Skeletal fluorosis is a bone and joint condition associated with prolonged exposure to high concentrations of fluoride. Fluoride increases bone density and appears to exacerbate the growth of osteophytes present in the bone and joints, resulting in joint stiffness and pain. The condition is categorized into one of four stages: a preclinical stage and three clinical stages that increase in severity. The most severe stage (clinical stage III) historically has been referred to as the "crippling" stage. At stage II, mobility is not significantly

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affected, but it is characterized by chronic joint pain, arthritic symptoms, slight calcification of ligaments, and osteosclerosis of the cancellous bones. Whether EPA's MCLG of 4 mg/L protects against these precursors to more serious mobility problems is unclear.

Few clinical cases of skeletal fluorosis in healthy U.S. populations have been reported in recent decades, and the committee did not find any recent studies to evaluate the prevalence of the condition in populations exposed to fluoride at the MCLG. Thus, to answer the question of whether EPA's MCLG protects the general public from stage II and stage III skeletal fluorosis, the committee compared pharmacokinetic model predictions of bone fluoride concentrations and historical data on iliac-crest bone fluoride concentrations associated with the different stages of skeletal fluorosis. The models estimated that bone fluoride concentrations resulting from lifetime exposure to fluoride in drinking water at 2 mg/L (4,000 to 5,000 mg/kg ash) or 4 mg/L (10,000 to 12,000 mg/kg ash) fall within or exceed the ranges historically associated with stage II and stage III skeletal fluorosis (4,300 to 9,200 mg/kg ash and 4,200 to 12,700 mg/kg ash, respectively). However, this comparison alone is insufficient for determining whether stage II or III skeletal fluorosis is a risk for populations exposed to fluoride at 4 mg/L, because bone fluoride concentrations and the levels at which skeletal fluorosis occurs vary widely. On the basis of the existing epidemiologic literature, stage III skeletal fluorosis appears to be a rare condition in the United Sates; furthermore, the committee could not determine whether stage II skeletal fluorosis is occurring in U.S. residents who drink water with fluoride at 4 mg/L. Thus, more research is needed to clarify the relationship between fluoride ingestion, fluoride concentrations in bone, and stage of skeletal fluorosis before any conclusions can be drawn.

Bone Fractures

Several epidemiologic studies of fluoride and bone fractures have been published since the 1993 NRC review. The committee focused its review on observational studies of populations exposed to drinking water containing fluoride at 2 to 4 mg/L or greater and on clinical trials of fluoride (20-34 mg/day) as a treatment for osteoporosis. Several strong observational studies indicated an increased risk of bone fracture in populations exposed to fluoride at 4 mg/L, and the results of other studies were qualitatively consistent with that finding. The one study using serum fluoride concentrations found no appreciable relationship to fractures. Because serum fluoride concentrations may not be a good measure of bone fluoride concentrations or long-term exposure, the ability to show an association might have been diminished in that study. A meta-analysis of randomized clinical trials reported an elevated risk of new nonvertebral fractures and a slightly decreased risk of vertebral

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fractures after 4 years of fluoride treatment. An increased risk of bone fracture was found among a subset of the trials that the committee found most informative for assessing long-term exposure. Although the duration and concentrations of exposure to fluoride differed between the observational studies and the clinical trials, bone fluoride content was similar (6,200 to more than 11,000 mg/kg ash in observational studies and 5,400 to 12,000 mg/kg ash in clinical trials).

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Overall, there was consensus among the committee that there is scientific evidence that under certain conditions fluoride can weaken bone and increase the risk of fractures. The majority of the committee concluded that lifetime exposure to fluoride at drinking-water concentrations of 4 mg/L or higher is likely to increase fracture rates in the population, compared with exposure to 1 mg/L, particularly in some demographic subgroups that are prone to accumulate fluoride into their bones (e.g., people with renal disease). However, 3 of the 12 members judged that the evidence only supports a conclusion that the MCLG *might not* be protective against bone fracture. Those members judged that more evidence is needed to conclude that bone fractures occur at an appreciable frequency in human populations exposed to fluoride at 4 mg/L and that the MCLG is not *likely* to be protective.

There were few studies to assess fracture risk in populations exposed to fluoride at 2 mg/L in drinking water. The best available study, from Finland, suggested an increased rate of hip fracture in populations exposed to fluoride at concentrations above 1.5 mg/L. However, this study alone is not sufficient to judge fracture risk for people exposed to fluoride at 2 mg/L. Thus, no conclusions could be drawn about fracture risk or safety at 2 mg/L.

Reproductive and Developmental Effects

A large number of reproductive and developmental studies in animals have been conducted and published since the 1993 NRC report, and the

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Neurotoxicity and Neurobehavioral Effects

Animal and human studies of fluoride have been published reporting adverse cognitive and behavioral effects. A few epidemiologic studies of Chinese populations have reported IQ deficits in children exposed to fluoride at 2.5 to 4 mg/L in drinking water. Although the studies lacked sufficient detail for the committee to fully assess their quality and relevance to U.S. populations, the consistency of the results appears significant enough to warrant additional research on the effects of fluoride on intelligence.

A few animal studies have reported alterations in the behavior of rodents after treatment with fluoride, but the committee did not find the changes to be substantial in magnitude. More compelling were studies on molecular, cellular, and anatomical changes in the nervous system found after fluoride exposure, suggesting that functional changes could occur. These changes might be subtle or seen only under certain physiological or environmental conditions. More research is needed to clarify the effect of fluoride on brain chemistry and function.

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The chief endocrine effects of fluoride exposures in experimental animals and in humans include decreased thyroid function, increased calcitonin activity, increased parathyroid hormone activity, secondary hyperparathyroidism, impaired glucose tolerance, and possible effects on timing of sexual maturity. Some of these effects are associated with fluoride intake that is achievable at fluoride concentrations in drinking water of 4 mg/L or less, especially for young children or for individuals with high water intake. Many of the effects could be considered subclinical effects, meaning that they are not adverse health effects. However, recent work on borderline hormonal imbalances and endocrine-disrupting chemicals indicated that adverse health effects, or increased risks for developing adverse effects, might be associated with seemingly mild imbalances or perturbations in hormone concentrations. Further research is needed to explore these possibilities.

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Effects on Other Organ Systems

The committee also considered effects on the gastrointestinal system, kidneys, liver, and immune system. There were no human studies on drinking water containing fluoride at 4 mg/L in which gastrointestinal, renal, hepatic, or immune effects were carefully documented. Case reports and in vitro and animal studies indicated that exposure to fluoride at concentrations greater than 4 mg/L can be irritating to the gastrointestinal system, affect renal tissues and function, and alter hepatic and immunologic parameters. Such effects are unlikely to be a risk for the average individual exposed to fluoride at 4 mg/L in drinking water. However, a potentially susceptible subpopulation comprises individuals with renal impairments who retain more fluoride than healthy people do.

Genotoxicity and Carcinogenicity

Many assays have been performed to assess the genotoxicity of fluoride. Since the 1993 NRC review, the most significant additions to the database are in vivo assays in human populations and, to a lesser extent, in vitro assays with human cell lines and in vivo experiments with rodents. The results of the in vivo human studies are mixed. The results of in vitro tests are also conflicting and do not contribute significantly to the interpretation of the existing database. Evidence on the cytogenetic effects of fluoride at environmental concentrations is contradictory.

Whether fluoride might be associated with bone cancer has been a subject of debate. Bone is the most plausible site for cancer associated with fluoride because of its deposition into bone and its mitogenic effects on bone cells in culture. In a 1990 cancer bioassay, the overall incidence of osteosarcoma in male rats exposed to different amounts of fluoride in drinking water showed a positive dose-response trend. In a 1992 study, no increase in osteosarcoma was reported in male rats, but most of the committee judged the study to have insufficient power to counter the evidence for the trend found in the 1990 bioassay.

Several epidemiologic investigations of the relation between fluoride and cancer have been performed since the 1993 evaluation, including both individual-based and ecologic studies. Several studies had significant methodological limitations that made it difficult to draw conclusions. Overall, the results are mixed, with some studies reporting a positive association and others no association.

On the basis of the committee's collective consideration of data from humans, genotoxicity assays, and studies of mechanisms of action in cell systems (e.g., bone cells in vitro), the evidence on the potential of fluoride to initiate or promote cancers, particularly of the bone, is tentative and

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mixed. Assessing whether fluoride constitutes a risk factor for osteosarcoma is complicated by the rarity of the disease and the difficulty of characterizing biologic dose because of the ubiquity of population exposure to fluoride and the difficulty of acquiring bone samples in nonaffected individuals.

A relatively large hospital-based case-control study of osteosarcoma and fluoride exposure is under way at the Harvard School of Dental Medicine and is expected to be published in 2006. That study will be an important addition to the fluoride database, because it will have exposure information on residence histories, water consumption, and assays of bone and toenails. The results of that study should help to identify what future research will be most useful in elucidating fluoride's carcinogenic potential.

DRINKING-WATER STANDARDS

Maximum-Contaminant-Level Goal

In light of the collective evidence on various health end points and total exposure to fluoride, the committee concludes that EPA's MCLG of 4 mg/L should be lowered. Lowering the MCLG will prevent children from developing severe enamel fluorosis and will reduce the lifetime accumulation of fluoride into bone that the majority of the committee concludes is likely to put individuals at increased risk of bone fracture and possibly skeletal fluorosis, which are particular concerns for subpopulations that are prone to accumulating fluoride in their bones.

To develop an MCLG that is protective against severe enamel fluorosis, clinical stage II skeletal fluorosis, and bone fractures, EPA should update the risk assessment of fluoride to include new data on health risks and better estimates of total exposure (relative source contribution) for individuals. EPA should use current approaches for quantifying risk, considering susceptible subpopulations, and characterizing uncertainties and variability.

Secondary Maximum Contaminant Level

The prevalence of severe enamel fluorosis is very low (near zero) at fluoride concentrations below 2 mg/L. From a cosmetic standpoint, the SMCL does not completely prevent the occurrence of moderate enamel fluorosis. EPA has indicated that the SMCL was intended to reduce the severity and occurrence of the condition to 15% or less of the exposed population. The available data indicate that fewer than 15% of children will experience moderate enamel fluorosis of aesthetic concern (discoloration of the front teeth) at that concentration. However, the degree to which moderate enamel fluorosis might go beyond a cosmetic effect to create an adverse psychological effect or an adverse effect on social functioning is not known.

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OTHER PUBLIC HEALTH ISSUES

The committee's conclusions regarding the potential for adverse effects from fluoride at 2 to 4 mg/L in drinking water do not address the lower exposures commonly experienced by most U.S. citizens. Fluoridation is widely practiced in the United States to protect against the development of dental caries; fluoride is added to public water supplies at 0.7 to 1.2 mg/L. The charge to the committee did not include an examination of the benefits and risks that might occur at these lower concentrations of fluoride in drinking water.

RESEARCH NEEDS

As noted above, gaps in the information on fluoride prevented the committee from making some judgments about the safety or the risks of fluoride at concentrations of 2 to 4 mg/L. The following research will be useful for filling those gaps and guiding revisions to the MCLG and SMCL for fluoride.

- Exposure assessment

— Improved assessment of exposure to fluoride from all sources is needed for a variety of populations (e.g., different socioeconomic conditions). To the extent possible, exposures should be characterized for individuals rather than communities, and epidemiologic studies should group individuals by exposure level rather than by source of exposure, location of residence, or fluoride concentration in drinking water. Intakes or exposures should be characterized with and without normalization for body weight. Fluoride should be included in nationwide biomonitoring surveys and nutritional studies; in particular, analysis of fluoride in blood and urine samples taken in these surveys would be valuable.

- Pharmacokinetic studies

— The concentrations of fluoride in human bone as a function of exposure concentration, exposure duration, age, sex, and health status should be studied. Such studies would be greatly aided by noninvasive means of measuring bone fluoride. Information is particularly needed on fluoride plasma and bone concentrations in people with small-to-moderate changes in renal function as well as in those with serious renal deficiency.

— Improved and readily available pharmacokinetic models should be developed. Additional cross-species pharmacokinetic comparisons would help to validate such models.

- Studies of enamel fluorosis

— Additional studies, including longitudinal studies, should be done in U.S. communities with water fluoride concentrations greater than 1 mg/L.

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These studies should focus on moderate and severe enamel fluorosis in relation to caries and in relation to psychological, behavioral, and social effects among affected children, their parents, and affected children after they become adults.

— Methods should be developed and validated to objectively assess enamel fluorosis. Consideration should be given to distinguishing between staining or mottling of the anterior teeth and of the posterior teeth so that aesthetic consequences can be more easily assessed.

— More research is needed on the relation between fluoride exposure and dentin fluorosis and delayed tooth eruption patterns.

- Bone studies

— A systematic study of clinical stage II and stage III skeletal fluorosis should be conducted to clarify the relationship between fluoride ingestion, fluoride concentration in bone, and clinical symptoms.

— More studies of communities with drinking water containing fluoride at 2 mg/L or more are needed to assess potential bone fracture risk at these higher concentrations. Quantitative measures of fracture, such as radiologic assessment of vertebral body collapse, should be used instead of self-reported fractures or hospital records. Moreover, if possible, bone fluoride concentrations should be measured in long-term residents.

- Other health effects

— Carefully conducted studies of exposure to fluoride and emerging health parameters of interest (e.g., endocrine effects and brain function) should be performed in populations in the United States exposed to various concentrations of fluoride. It is important that exposures be appropriately documented.

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MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 041-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Proposed Alcohol Related Resolutions for the 2011 Association 0f Local Public Health Agencies Annual Meeting

Recommendations

It is recommended:

1. That the Board of Health endorse the resolutions related to alcohol attached as Appendices A and B to Report No. 041-11; and further
2. That these resolutions be forwarded to the Association of Local Public Health Agencies (alPHa) for consideration at the 2011 alPHa Annual Meeting.

Background

The research community (Appendix C) has consistently found that increased availability and access to alcohol is associated with increases in consumption and alcohol-related harms. Furthermore, researchers have agreed that regulating the physical availability of alcohol, including restrictions on sales, is one of the top alcohol policy practices in reducing harm (World Health Organization, 2009 and Barbor et al., 2010).

Today, alcohol continues to be a prominent concern as it contributes to both economic and health impacts in our community. In 2002, the annual costs in Canada for health care, directly related to alcohol consumption was $3.3 billion, and the total direct and indirect costs was $14.6 billion (Rehm et al., 2009). Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions including injury (impaired driving, drowning, falls, fires, suicide, homicide, sexual assault and other violence) and chronic disease (liver disease, cancers, high blood pressure, mental health problems, and stroke) (Barbor et al., 2010; Rehm et al., 2009; Roerecke et al., 2007). Locally, alcohol consumption rates are higher than the provincial average and pose a significant risk to our community:

- The 2009 Ontario Student Drug Use and Health Survey indicates that general alcohol use in the last year, binge drinking, and hazardous drinking, among students Grades 9-12 was higher in the South West Local Health Integration Network (LHIN) area (82.3%, 46.5%, and 35% respectively) than the provincial average (69.4%, 32.9% , and 27.5% respectively).

- Adult alcohol use in the South West LHIN area (2007) was also higher than the province in general alcohol use in the last year (84% vs. 81%), exceeding drinking guidelines (26% vs. 23%), hazardous drinking (18% vs. 16%), and weekly binge drinking (13% vs. 11%).

Currently access to alcohol in Ontario is readily available with 7-day a week sales and at a wide variety of buying venues. As of 2009/2010 there were 611 Liquor Control Board of Ontario (LCBO) stores, 436 The Beer Store (TBS) locations, and 216 agency stores (independent local retailers authorized to sell LCBO and TBS products in smaller towns across Ontario) with a total of 188 million store transactions. In addition to these stores, as of 2008/2009 there were 16,663 Liquor Licensed Establishments (bars and restaurants) and a further 56,143 Special Occasion Permits Issued in Ontario (LCBO, TBS, and Alcohol & Gaming Commission of Ontario [AGCO] Annual Reports).

Although alcohol revenue from taxes is often touted as a financial benefit to the province, it is important to understand the countering health and economic costs associated with alcohol use. In 2002-2003, alcohol cost the province $456 million more in direct health care and law enforcement costs than the net revenue and sales tax brought in from LCBO as indicated by Gerald Thomas, senior research and policy analyst at the Canadian Centre on Substance Abuse (CCSA) in September 2010. Above and beyond these direct costs there are also billions of dollars spent in indirect costs related to alcohol including lost productivity, absenteeism, victim assistance, and addiction/preventative services.

Boards of Health play a key role in a comprehensive approach (prevention, harm reduction, treatment, criminal justice, and advocating for healthy public policy) to reduce risk of injuries and chronic disease related to alcohol. This Board of Health has proven its commitment to responsible action concerning healthy alcohol policy and supportive environments through the endorsement of the March 2008, alcohol related resolutions sent to the 2008 alPHa Annual Meeting (Report No. 026–08) (Appendix D).

Current Issue

Ontario Attorney General, The Honourable Chris Bentley, announced in February 2011 that the Ontario government would be exploring changes to the alcohol regulatory system, the Liquor Licence Act (LLA) of Ontario, in the areas of licensing and enforcement (Appendix E). Of greatest concern, are those proposed modifications that increase access/availability to alcohol. This includes the amendments "giving the public more freedom to circulate in festival areas including the retail area with drinks;" "extending the hours that alcohol can be served at special events;" and "allowing all-inclusive vacation packages to be sold in Ontario."

Prior to any changes being legislated to the current LLA it is imperative that a formal review and impact analysis of the health and economic effects of alcohol in Ontario is completed. Ontario, unlike British Columbia, Nova Scotia, Saskatchewan, Quebec and Alberta which is in progress, does not have a provincial alcohol strategy although identified as a required best practice in the prevention of alcohol related injuries, deaths and diseases.

To that end, two resolutions have been drafted for submission to the Association of Local Public Health Agencies 2011 Annual Meeting. The resolutions call for:

1. A formal review and impact analysis of the health and economic effects of alcohol in Ontario and thereafter the development of a provincial Alcohol Strategy (Appendix A); and
2. Maintaining the Liquor Licence Act (LLA) of Ontario in its current form until the review and development of a provincial alcohol strategy have been completed (Appendix B).

Conclusion

Alcohol is a public health issue. Alcohol policies play a vital role in the health and safety of communities. While such policies can reduce harm and health risks when effectively researched and implemented, they can likewise increase harm and health risks when weakened by unsounded changes. The resolution put forward would provide a complete picture of the health and economic impact of alcohol in Ontario and thus provide information to strengthen regulatory legislation and to develop a comprehensive provincial alcohol strategy to reduce alcohol related harm, death and diseases.

This report was written by Mary Lou Albanese, Manager Healthy Communities and Injury Prevention and Melissa Rennison, PHN, Healthy Communities and Injury Prevention.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Prevention of Injury and Substance Misuse and Chronic Diseases and Injuries Appendix A

TITLE Conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and thereafter develop a provincial Alcohol Strategy

SPONSOR Middlesex-London Board of Health

WHEREAS There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol; and (Barbor et al., 2010)

WHEREAS Ontario has a significant portion of the population drinking alcohol (81.5%), exceeding the low risk drinking guidelines (23.4%), consuming 5 or more drinks on a single occasion weekly (11.2%), and reporting hazardous or harmful drinking (15.6%); and (CAMH Monitor)

WHEREAS Ontario youth (grades 9-12) have concerning levels of alcohol consumption with 69.4% having drank in the past year, 32.9% binge drinking (5 or more drinks), and 27.5% of students reporting drinking at a hazardous level; and (OSDUHS Report)

WHEREAS Each year alcohol puts this province in a $456 million deficit due to direct costs related to healthcare and enforcement; and (G. Thomas, CCSA)

WHEREAS Billions of dollars are spent each year in Canada on indirect costs associated with alcohol use (illness, disability, and death) including lost productivity in the workplace and home; and (The Costs of Sub Abuse in CAN, 2002)

WHEREAS Nearly half of all deaths attributable to alcohol are from injuries including unintentional injuries (drowning, burns, poisoning and falls) and intentional injuries (deliberate acts of violence against oneself or others); and (WHO – Alcohol and Injury in EDs, 2007)

WHEREAS Regulating the physical availability of alcohol is one of the top alcohol policy practices in reducing harm; and (Barbor et al., 2010)

WHEREAS The World Health Organization (WHO, 2011) has indicated that alcohol is the world's third largest risk factor for disease burden and that the harmful use of alcohol results in approximately 2.5 million deaths each year. Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions; and

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and develop a provincial Alcohol Strategy.

Appendix B

TITLE Maintain the Current Liquor Licence Act (LLA) of Ontario

SPONSOR Middlesex-London Board of Health

WHEREAS Removing designated alcohol areas at events jeopardizes the ability of servers/bar tenders to monitor the number of drinks one person has consumed and as a result, increases the possibility of over-service, over-consumption and alcohol-related harms; and (Barbor et al., 2010)

WHEREAS Removing designated alcohol areas at events increases the risks that underage youth would be able to sneak into the event either with their own alcohol or may have access to alcohol purchased by someone of legal drinking age; and (Barbor et al., 2010)

WHEREAS Alcohol consumption affects a person's judgment, coordination and reflexes and thus allowing for tiered seating is likely to increase the amount of injuries at events; and (Barbor et al., 2010)

WHEREAS There is strong and consistent evidence from a number of countries that changes to hours or days of sale have significant impacts on the volume of alcohol consumed and on the rates of alcohol-related problems; and (Barbor et al., 2010; Vingilis et al., 2007; Vingilis et al., 2005; Stockwell & Chikritzhs, 2009)

WHEREAS Research shows that the provision of alcohol at reduced or no cost increases overall alcohol consumption; and (Barbor et al., 2010; Giesbrecht et al., 2008; Mann et al., 2005)

WHEREAS Allowing the public with alcohol into areas of a restaurant, such as the kitchen, raises concerns regarding food safety and sanitation; and

WHEREAS Allowing tourist operators to offer fixed price packages that include liquor makes it difficult for servers/bar tenders to monitor the number of drinks one person has consumed and as a result, increases the risk of over-service, over-consumption and alcohol-related harms. Under the Liquor Licence Act, it is illegal to serve customers to intoxication. In an "all-you-can-drink" environment, this law is severely compromised; and (Barbor et al., 2010; Thombs et al., 2009)

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to maintain the Liquor Licence Act (LLA) of Ontario as it is currently written until a formal review and impact analysis of the health and economic effects of alcohol in Ontario is completed.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 042-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Intensive Intervention for Smoking Cessation

Recommendation
It is recommended that Report No. 042-11 re Intensive Intervention for Smoking Cessation be received for information.

Background
In working with families in the Healthy Babies Healthy Children (HBHC) program, staff members continue to be confronted with the challenges of supporting clients who are smoking. The clients may be pregnant, have newborn infants or young children. The impact of the smoking is detrimental to their health and the health of their families. Young children are at risk of health related illnesses including respiratory illnesses, sudden infant death syndrome and slowing growth and development. Smoking during pregnancy results in a number of adverse health outcomes for the mother and baby. Most notably, it increases the risk of preterm deliveries and low birth weights. The Canadian Community Health Survey reports that 17% of women smoke during their pregnancy and in southwestern Ontario, it is reported that 18.6% of pregnant women are smoking. While a number of women quit smoking early into their pregnancies, vulnerable women belonging to a low socio-economic group are less likely to quit, especially without the aid of pharmacotherapy. This is also true for any women who smoke and have limited economic supports.

Intensive Interventions Initiative
The Intensive Interventions Smoking Cessation initiative has been implemented by Public Health Nurses (PHN's) and Family Home Visitors (FHV's) who are working with at risk and vulnerable families every day. Home visiting program staff members have integrated the recommendations from Registered Nurses Association of Ontario (RNAO) Best Practice Guideline: Integrating Smoking Cessation into daily nursing practice. All families are assessed, counseled and provided with resources if they are currently smoking. These actions are documented. However this proven strategy is only part of the puzzle and more in-depth interventions have not been a standard of practice.

The goal of this Intensive Intervention initiative is to provide intensive interventions (duration greater than 10 minutes) to support families to make their home smoke free, and to support women who are pregnant and postpartum to quit smoking. A number of activities were developed and implemented, including the following:

- Creating and delivering a workshop to enhance the ability of staff to provide more intensive interventions for smoking cessation (assessment, resources and interventions)
- Identifying a number of common resources for supporting clients in creating a smoke free environment, reducing smoking or quitting smoking
- Complete comprehensive smoking assessment with the client and together develop a "quit plan"
- Provide on going supportive counselling to individuals and couples to increase likeliness of success
- Providing free Nicotine Replacement Therapy (NRT) for clients in need, including clients who are pregnant or breastfeeding.

NRT is a necessary component of the intensive smoking cessation intervention. Literature suggests that combining cessation strategies can almost double long-term success rates. A clinical review from the Canadian Family Physician journal recommends that in order to achieve greater success with client cessation, providing NRT, supportive counseling and telephone support is optimal. Because the HBHC staff members have access to families needing support and builds relationships with them, staff members are able to make a difference by providing the support needed to help clients through the challenges of quitting smoking. NRT is expensive to purchase and out of reach for many of the clients in the HBHC program. As a result, the Health Unit has purchased a supply of NRT to be distributed free of charge for ten clients.

All clients who smoke can be involved in a smoking cessation intervention, however, only nicotine addicted clients who have unsuccessfully tried to quit smoking in the past and are willing to try again can

be considered for NRT. They must also agree to receive 1:1 support from the HBHC nurses. NRT will be dispensed after the PHN has completed an assessment, devised a smoking cessation plan with the client and received a valid medical note from a treating physician or nurse practitioner. Clients will be monitored throughout their use of NRT.

Results to Date

The staff workshop entitled, Beyond the Ask: Intensive Intervention for Smoking Cessation, was delivered in January 2011. As a result, PHN's and FHV's have increased their confidence in performing more intensive interventions and are now using these skills in their daily practice. This is evident in that in just over a one month period, ten clients (some who are pregnant) have established a quit plan and are pursuing NRT. The progress of the program and the results of the NRT are being monitored and will be reported on in a future Board Report.

This report was prepared by Ms. Nancy Hamilton, PHN, and Ms. Nancy Summers, Manager, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Reproductive Health Standard Requirements 4 and Child Health Standard Requirement 6

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 043-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Ready for School - Thames Valley Neighbourhood Early Learning Program

Recommendation

It is recommended that Report No. 043-11 re Ready for School - Thames Valley Neighbourhood Early Learning Program be received for information.

Background

The Thames Valley Neighbourhood Early Learning Program (TVNELP) has existed for seven years, supporting parents to optimise their child's potential in school by engaging them in preparatory activities prior to starting school. During the 2009-2010 school year, the families of 3 and 4 year olds in the neighbourhoods of 82 schools, participated in activities provided by 18 early years community partners throughout the Thames Valley District School Board, encompassing three counties. The four half-day sessions focused on Healthy Living, Literacy, Numeracy and a classroom visit. Health Unit staff included the Child Health Team, tykeTALK, Dental Services and Child Safety Middlesex-London.

Child Health Team at TVNELP's in London and Middlesex County

The Public Health Nurses (PHNs) of the Child Health Team took part in the Healthy Living Day (Day 1) at 47 sites involving 53 schools (38 city sites and 9 county sites). PHNs assisted 467 families to complete the Nipissing Developmental Screens for 3 and 4 year old children, discussing healthy growth and development. In addition, 220 parents indicated they had completed the screening tool elsewhere e.g., School Enterers packages, Ontario Early Years Centers, Let's Grow etc., which was an increase from 156 the previous year. Six hundred and eighty (680) packages that included information about nutrition, physical activity, childhood resiliency, immunization, and safety were distributed to the families attending Day 1.

Twenty-one (4.5%) of the preschoolers whose parents completed the Nipissing with the PHN were identified with some level of developmental concern. Of this number, parents consented to the referral of 13 of the children for additional assessment by All Kids Belong consultants using the professional screen called the Diagnostic Inventory for Screening Children (DISC). Once the DISC is completed, referrals are then made to the appropriate community agency for interventions, promoting the philosophy "Don't Wait and See". With earlier intervention, there is increased potential for maximizing success at school. For the parents who did not consent to a referral, they were encouraged to discuss the results of the Nipissing with their family physician.

TVNELP's School Year (2010-2011)

The current year of TVNELP has brought significant change to the program. Child Health Team PHNs did provide information and feedback during the school board's review of the TVNELP program. As a result of the school board's review, the four half-day sessions have been decreased to three, consisting of a Healthy Living Day, a combined Literacy/Numeracy Day and a classroom visit. The number of schools and sites participating in the TVNELP program were reduced; there are 44 Middlesex-London schools participating at 41 sites. The changes provide more flexibility to enable schools to tailor the program to their particular school population. The impact of program changes on the number of children/families receiving support from Child Health Team PHNs is yet to be determined.

The Child Health Team, Dental Services, tyke Talk and Child Safety Middlesex London continue their involvement, but there is an exciting new participant from the Health Unit this year. The Dietitians from Family Health Services are piloting 'NutriSTEP®' at 10 TVNELP sites, representing a diverse sample of schools within London and Middlesex County.

NutriSTEP®

NutriSTEP® is a provincial questionnaire that is copyright protected and can only be obtained by acquiring a license. The questionnaire is for parents and caregivers of 3-5 year olds. It contains 17 questions (taking 5 minutes to complete) that address physical growth, food and nutrient intakes, factors affecting food intake and eating behaviour, developmental and physical capabilities and physical activity.

It is available in eight languages. Once NutriSTEP® is completed by the parent, a score will show if the child is identified at low, moderate or high risk for nutrition concerns. Registered Dietitians are implementing the provincial NutriSTEP® program at sessions from February to April 2011. An educational package was created for parents with children identified with moderate/high risk of nutrition concerns, and a referral map for nutrition support was created for use in making appropriate referrals.

Summary

The PHNs of the Child Health Team took part in the TVNELP Healthy Living Day (Day 1) at 47 sites involving 53 schools during the 2009-2010 school year. There have been significant changes made to current year of TVNELP, including the piloting of the NutriSTEP® program at ten TVNELP sites to assess the process and suitability of implementing this strategy on an ongoing basis.

This report was prepared by Ms. Roxanne Emery, Public Health Nurse, Child Health Team, Ms. Ginette Blake, Registered Dietitian, Family Health Promotion Team, and Ms. Heather Lokko, Manager, Child Health Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health Requirement #11

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 044-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

The Work of Public Health Nurses in Shelters

Recommendation

It is recommended that Report No. 044-11 re The Work of Public Health Nurses in Shelters be received for information.

Background

"I would like to say that poverty, in particular child poverty, is more than just a social justice issue or a political embarrassment. We would frame it also as a public health issue."
(Dr. Andrew Lynk, Canadian Paediatric Society, 2010)

The Registered Nurses Association of Ontario (RNAO) Policy on Homelessness states, "Adequate shelter is a basic prerequisite of health. Without it there are far reaching implications on other determinants of health." It has been well documented that homelessness has a significant negative impact on the health of people including children. In response to a recommendation from an inquest into the death of an infant in a shelter in Toronto (Jordan Hiekamp Inquest 2001), staff members have been providing regular and ongoing public health nursing services to women and families in shelters since 2002.

The causes of homelessness are complex and include poverty, lack of employment, lack of affordable housing and mental health. For individuals and families who are homeless, there are many health concerns that significantly increase their risk of death. Many of the women living in shelters are victims of domestic violence. They are living in fear and have been forced to move to the shelter to ensure the safety of themselves and their children.

PHN Work in Shelters

PHN's provide service to 7 women abuse and homeless shelters in London and Middlesex County: Women's Community House, Women's Community House-Clarke Road, Women's Community House-Second Stage Housing, Women's Rural Resource Centre, Zhaawanong Shelter, Rotholme Women's and Family Shelter and Salvation Army Centre of Hope. There are 200 beds and 50% of the residents are children. The PHN's provide resident consultations and referrals, health teaching, staff consultations and teaching related to infant growth and development, prenatal care, mental health and physical health of parents and children, substance abuse, immunization, communicable diseases, birth control and sexually transmitted diseases. Service to the shelters mainly focuses on the families who meet the criteria for the Health Babies/Healthy Children (HBHC) Program. When the families leave the shelter for more permanent housing, the nurses continue to follow the families with young babies in the HBHC Program.

Each year, there have been on average 500 client consultations with the shelter residents and 80-100 referrals to the HBHC Program. In 2009 and 2010 influenza immunization clinics were also provided to the shelters with the assistance of the Nurse Practitioner.

A Time for Renewal

In September 2010, HBHC program staff established a working group including PHN's, the Social Worker and a Manager to review service delivery, set up transition and mentoring for new staff working in the shelter settings, formalize the liaison role and ponder strategies to address some of the social justice issues so relevant to this population.

A review of the literature and a survey of the services to shelters provided by other health units in Ontario affirmed the present direction and involvement. Consultation with shelter staff and other community partners also explicitly identified a number of health issues such as women's health challenges, children's growth and development, limited prenatal care, sexual transmitted diseases, communicable diseases, increased rate of addictions and mental health issues, less access to preventative health care including immunizations, dental care and social inequities including struggles with transportation, accessing health care and challenges with follow-up care.

Conclusion

In addition to service delivery, the working group is focused on being the liaison for other service areas within the Health Unit to address inequities and challenges of shelter residents in accessing other Health Unit services, including Dental, STI/Birth Control Clinic, Nurse Practitioner, Vaccine Preventable Division, parenting resources, and Immunization Clinic. The liaison role also enables the Health Unit to connect with other agencies in the community with similar mandate and client challenges as the shelters such as My Sisters Place and the Unity Project. Although direct service may not be required, the Health Unit has a significant role in ensuring the sharing of relevant information and resources and supporting advocacy and policy development. The working group works together to identify common issues of social justice and address these through a collaboration process involving other community partners and appropriate community committees.

This enhanced framework for services provided to the shelters will be presented at the All Our Sisters National Conference May 9-11, 2011, in London, Ontario.

If any Board Member wishes to learn more about this program, including accompanying a PHN working in the shelters, s/he should contact Ms. Diane Bewick, Director, Family Health Services.

This report was prepared by Ms. Mary Huffman, PHN; Ms. Martha Kirkwood, PHN; Ms. Jody Shepherd, PHN; Ms. Kathy Dowsett, PHN; Ms. Meaghan Bolack, Social Worker and Ms. Nancy Summers, Manager, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Reproductive Health Standard Requirements 4 and Child Health Standard Requirement 6

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 045-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Nursing Practice Excellence

Recommendation

It is recommended that Report No. 045-11 re Nursing Practice Excellence be received for information.

Background

The Ontario Public Health Standards encourage the building and sustaining of the Health Unit workforce by providing ongoing staff development and skill building opportunities related to public health competencies. Below are three key areas where nursing educational opportunities and supports continue to ensure a high level of professional performance.

Nursing Practice Council 2010 Annual Report

The Health Unit's Nursing Practice Council (NPC) has been in existence since 2002. The purpose of NPC is to contribute to quality assurance in nursing practice, a quality work environment and excellence in practice by identifying and responding to professional practice issues. The membership of NPC consists of the professional Nurse Leader, Community Health Nursing Specialist, Managers from several service areas, a Human Resources and Labour Relations representative, ONA President or designate, and staff nurses representing different areas of practice. A copy of the revised NPC brochure provides an overview of the mission, values and beliefs (Appendix A).

The three strategic plan objectives for 2010/2011 include:

- Exploration of professional nursing practice change issues and processes
- Completion of a needs assessment survey
- Adoption of the new performance appraisal tool that incorporates the Public Health Nursing Discipline Specific Competencies

In 2010, members of NPC continued to work towards the mandate of supporting nurses towards excellence in practice. A copy of the 2010 Nursing Practice Council Annual Report summarizes the achievements of the Council (Appendix B). This report will be shared with all nurses along with a needs assessment survey that will evaluate the function of the Council and set future directions.

All Nurses Meeting

In May 2009, the Community Health Nurses of Canada released the Public Health Nursing (PHN) Discipline Specific Competencies. This document was based on the Core Competencies for Public Health in Canada (2007). The PHN Specific Competencies define the essential skills, knowledge and abilities required for the practice of public health nursing.

In 2010, all nurses were required to participate in the revised College of Nurses' (CNO) Quality Assurance program. This mandatory program measures the knowledge and application of the College's practice documents and requires the development of annual learning plans.

On October 22, 2010, an All Nurses Meeting was held with Ms. Myra Kreick (CNO Outreach Consultant Community and Public Health) and Ms. Katie Dilworth (Professional Practice Consultant with Toronto Public Health, and President of the Community Health Nurses' Initiative Group). The objective was to assist nurses to meet the revised CNO Quality Assurance program requirements, as well as explore the PHN Competencies and the convergence of competing professional requirements. In total, 91 nurses attended this meeting with the majority of evaluation respondents indicating an increase in their knowledge of both the Quality Assurance program and the PHN Competencies. A presentation on this innovative collaboration will be co-presented by the Community Health Nursing (CHN) Specialist at the 5th National Community Health Nurses Conference, May 16-18, 2011.

The next meeting will be held on April 14, 2011, with the objective of providing education to nurses on the two selected practice documents required for this year's CNO Quality Assurance program. These two areas of practice focus for 2011 are documentation and infectious disease prevention.

Community Health Nursing Certification
Since 1991, the Canadian Nurses Association (CNA) has offered certification credentials as part of a respected national certification program. Certification in CHN has been available since 2006.

Each year, the CHN Specialist organizes a study group for staff and community health nurses outside of the organization seeking certification. In addition, a certification guide book developed in partnership with Para-Med Home Health Care is revised and posted on the Canadian Health Nurses Association of Canada website to support certification candidates across the country. The guidebook contains information regarding facilitation of and participation in a study group, reading lists for each competency, links to a variety of web-based resources, and review and practice questions to support engagement in reflective practice discussions.

Successful Health Unit CHN Certification recipients in 2010 from Family Health Services included Ms. Jayne Scarterfield, Ms. Bonnie Wooten, Ms. Erin Wilcox; and from Oral Health, Communicable Disease and Sexual Health Services, Ms. Erica Zarins. To date, 36 Public Health Nurses (3 former employees) have achieved national certification.

Eight additional nurses along with five from other agencies are currently meeting in a weekly study group, and will write the national certification examination on April 9, 2011.

Summary
Building and sustaining a nursing workforce which continues to provide quality practice in all aspects of care remains the goal of these cumulative initiatives. The recent needs assessment survey will provide additional information from nurses which will guide future professional development initiatives.

This report was prepared by Ms. Diane Bewick, Director, Family Health Services and Senior Nurse Leader, and Ms. Brenda Marchuk, Community Health Nursing Specialist, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundational Standard related to building and sustaining the public health workforce.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 046-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 April 14

Appointment of Mr. Al Edmondson to AlPHa Board Of Directors

Recommendation
It is recommended that the Board of Health endorse the nomination of Mr. Al Edmondson for appointment to the Association of Local Public Health Agencies (alPHa) Board of Directors for the 2 year term beginning June 2011, ending June 2013.

Attached as Appendix A is recently received correspondence from Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies (alPHa), advising of Mr. Al Edmondson's immediate appointment to the alPHa Board of Directors.

As this appointment expires June 13, 2011, a Board of Health resolution is required supporting Mr. Edmondson's nomination for the 2 year term beginning June 2011, ending June 2013.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health