Supporting the Health of Newly Arrived Refugees in Primary Care

PANELIST

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WITH

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Ontario College of Family Physicians

Family & Community Medicine
UNIVERSITY OF TORONTO

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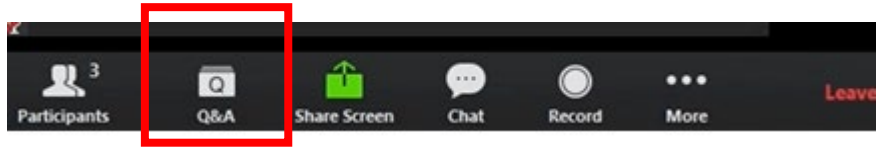

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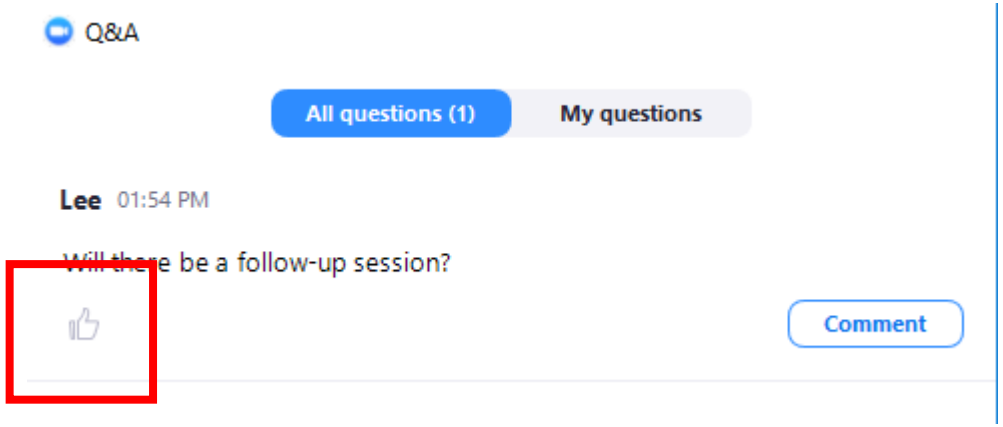

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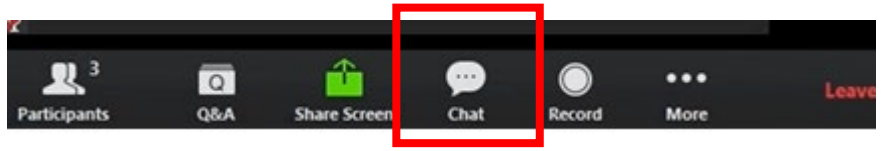

Your Panelist: Disclosures

Dr. Meb Rashid

- Relationships with financial sponsors:
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Potential for conflict(s) of interest: There are NO conflicts of interest for the speaker

Dr. Jobin Varughese

- Relationships with financial sponsors:
  - OCFP President, Family Physician, Assistant Dean of Primary Care Education for the School of Medicine at Toronto Metropolitan University (TMU), Brampton, ON

Dr. Doug Gruner

- Relationships with financial sponsors:
- Speakers Bureau/Honoraria: Ontario College of Family Physicians

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<u>Potential for conflict(s) of interest</u>:
N/A

Mitigating Potential Bias

- The Program Advisors have control over the choice of topics and speakers.
- Content has been developed according to the standards and expectations of the Mainpro+ certification program.
- The program content was reviewed by program advisors.

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.

Supporting the Health of Newly Arrived Refugees in Primary Care

Health Equity Community of Practice

Nov. 27, 2024

Dr. M. Rashid
Medical Director-Crossroads Clinic, Women's College Hospital

I have no conflict of interest to declare

Overview

- Refugee Nomenclature
- Immigration Medical Exam
- Common Health Issues in Refugees
- Health Insurance for Refugees

Immigration to Canada-2024 (Total-483,000)

Refugees: Are we talking about the same populations?

What is the definition of "Refugee"?

Forced Migrants

- Undocumented migrants
- Temporary Foreign Workers
- CUAET visa for Ukrainians
- And more…..

1951 United Nations Geneva Convention Relating to the Status of Refugees:

- a person owing to a well-founded fear of being **persecuted**
- for reasons of race, religion, nationality, membership of a particular social group, or political opinion,
- is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country

Not all refugees are the same

Refugee nomenclature in Canada

Resettled Refugees

- Government Assisted Refugees (GARs)
- Privately Sponsored Refugees (PSRs)

Refugee Claimants

- *elsewhere referred to as asylum seekers*

Note: distinction from other forced migrants, such as those without status

Difference Between Resettled Refugees vs Refugee claimants?

Pre-migration

- Length of time since initial trauma
- Selection bias
- Journeys

Post-migration

- Impact of unresolved immigration status
- OHIP access

Do Refugee Get Screened Before Coming to Canada?

IMMIGRATION MEDICAL EXAM

Cursory evaluation of health condition that may suggest

1. a condition that could place an excessive demand on the public health care or social service system in Canada
2. a serious communicable disease

Immigration Medical Exam

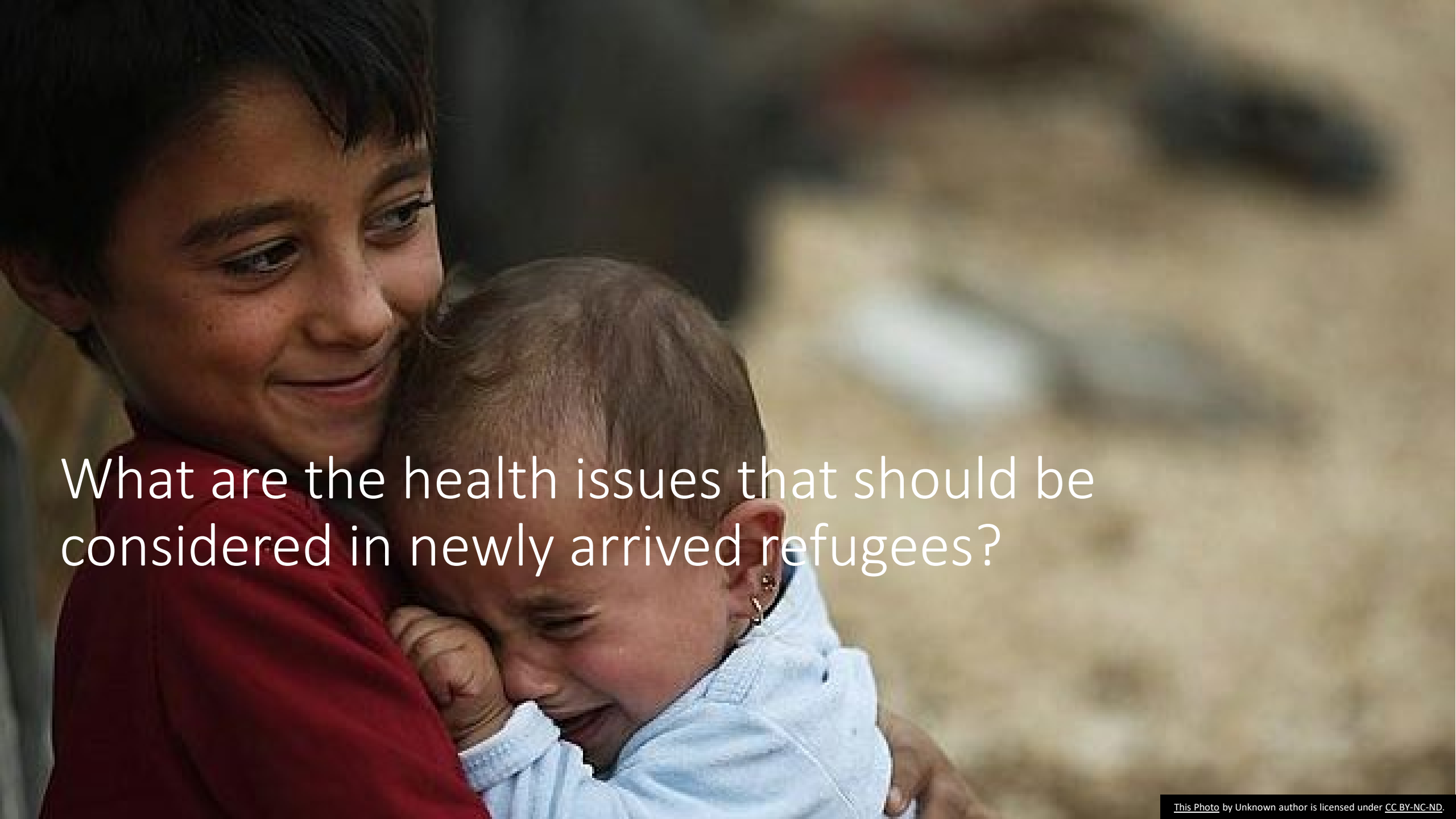
The immigration CPX includes the following:

-A history and physical exam

-The following laboratory tests

1. Syphilis (≥ 15 y.o.)
2. HIV (≥ 15y.o.)
3. CXR (≥ 11y.o.)
4. Urinalysis (≥ 5y.o.)

IGRA's and viral hepatitis testing in certain scenarios eg HIV +ve



What are the health issues that should be considered in newly arrived refugees?

GUIDELINES CMAJ

Evidence-based clinical guidelines for immigrants and refugees

Kevin Pottie MD MClSc, Christina Greenaway MD MSc, John Feightner MD MSc, Vivian Welch MSc PhD, Helena Swinkels MD MHSc, Meb Rashid MD, Lavanya Narasiah MD MSc, Laurence J. Kirmayer MD, Erin Ueffing BHSc MHSc, Noni E. MacDonald MD MSc, Ghayda Hassan PhD, Mary McNally DDS MA, Kamran Khan MD MPH, Ralf Buhrmann MDCM PhD, Sheila Dunn MD MSc, Arunmozhi Dominic MD, Anne E. McCarthy MD MSc, Anita J. Gagnon MPH PhD, Cécile Rousseau MD, Peter Tugwell MD MSc; and coauthors of the Canadian Collaboration for Immigrant and Refugee Health

CMAJ 2011. DOI:10.1503/cmaj.090313

Canadian Collaboration on Immigrant and Refugee Health: *Selected Topics*

Infectious Diseases

- Hepatitis B
- Hepatitis C
- HIV
- Intestinal Parasites
- Malaria
- MMR/DPTP-HIB
- Tuberculosis
- Varicella (Chicken Pox)

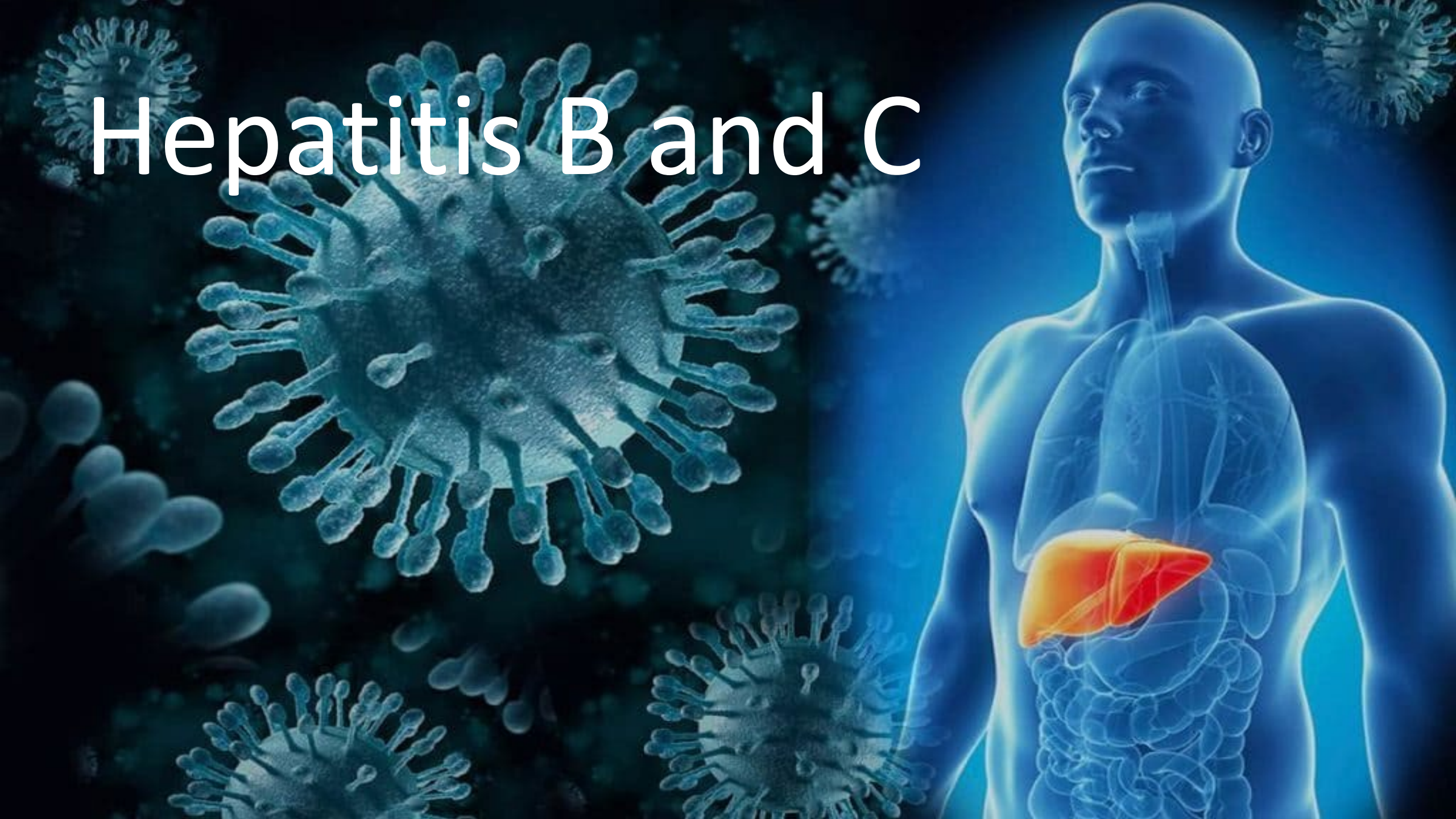
Mental Health

- Depression
- Post Traumatic Stress Disorder
- Child Maltreatment
- Intimate Partner Violence

Other Chronic Disease

- Cancer of the Cervix
- Unmet Contraceptive Needs
- Diabetes
- Dental Caries/Peridontal disease
- Iron Deficiency Anemia
- Pregnancy Care
- Vision Disorders

Hepatitis B and C



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RESEARCH ARTICLE

Seroprevalence of Chronic Hepatitis B Virus Infection and Prior Immunity in Immigrants and Refugees: A Systematic Review and Meta-Analysis

Carmine Rossi, Ian Shrier, Lee Marshall, Sonya Cnossen, Kevin Schwartzman, Marina B. Klein, Guido Schwarzer, Chris Greenaway

Published: September 5, 2012 • https://doi.org/10.1371/journal.pone.0044611

Abstract

Background

International migrants experience increased mortality from hepatocellular carcinoma compared to host populations, largely due to undetected chronic hepatitis B infection (HBV). We conducted a systematic review of the seroprevalence of chronic HBV and prior immunity in migrants arriving in low HBV prevalence countries to identify those at highest risk in order to guide disease prevention and control strategies

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RESEARCH ARTICLE

Seroprevalence of Chronic Hepatitis B Virus Infection and Prior Immunity in Immigrants and Refugees: A Systematic

Seroprevalence rate in migrants was 7.2%

Refugees were 1.7X more likely to be infected

Note of increased risk of HCC in migrants

Abstract

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Hepatitis B vaccination

Vaccine: currently provided in Toronto if

1. Household/sexual contact
2. MSM
3. IDU’s
4. Multiple sexual partners
5. chronic liver disease (incl. Hep C)
6. dialysis
7. premature infants
8. Grade seven
9 . ***Children with parents from endemic areas

Estimated prevalence of hepatitis B and C among immigrants in Canada

Laurence Campeau[1], Janelle Elliott[1], Anson Williams[1], Simone Périnet[1], Qiuying Yang[1], Joseph Cox[2], Jordan J Feld[3], Christina Greenaway[4], Nashira Popovic[1]

Abstract

Background: Canada's Sexually Transmitted and Blood-borne Infections (STBBI) Action Plan and the Global Health Sector Strategies on STBBI highlight the importance of putting people at the centre of the health system response. Several key populations are disproportionately affected by viral hepatitis, including immigrants. However, there is a limited body of evidence on the burden of viral hepatitis among immigrants in Canada. We seek to address this gap by estimating the prevalence of hepatitis B (HBV) and C (HCV) infections among immigrants in Canada.

Methods: Using country- and region-specific publicly available data on the prevalence of HBV and HCV, we estimated the number of immigrants with chronic HBV (CHB), HCV antibodies, and chronic HCV (CHC) by multiplying the number of immigrants from Statistics Canada's 2021 census of population data by the corresponding publicly available country or region-of-origin prevalence, including lower and upper bounds. Each country was categorized as low (<2%) or intermediate-to-high (≥2%) based on published prevalence. To capture changes over time, estimates were stratified by time-period, where possible.

Results: In 2021, the estimated prevalence of viral hepatitis among all immigrants was 4.03% for CHB, 1.43% for HCV antibodies, and 0.78% for CHC. The estimated prevalence of CHB, HCV antibodies, and CHC was 0.91%, 0.96% and 0.52%, respectively, among immigrants from low-prevalence countries (<2%). It was 5.57%, 4.04%, and 2.20%, respectively, among immigrants from intermediate-to-high-prevalence countries (≥2%).

Conclusion: This is the first study to estimate the burden of HBV and HCV among immigrants at the national level in Canada. The results show that the prevalence of viral hepatitis among immigrants is higher than the general Canadian population. However, grouping all immigrants into one category masks important variation, and potentially over-estimates the burden of HBV and HCV among immigrants. Strengthening our understanding of hepatitis prevalence among immigrants can improve our ability to connect those in need to care and treatment services.

Affiliations

[1] Public Health Agency of Canada, Ottawa, ON

[2] Department of Epidemiology, Biostatistics and Occupational Health, McGill University, Montréal, QC

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Suggested citation: Campeau L, Elliott J, Williams A, Périnet S, Yang Q, Cox J, Feld JJ, Greenaway C, Popovic N. Estimated prevalence of hepatitis B and C among immigrants in Canada. Can Commun Dis Rep 2025;51(6/7):214–22. https://doi.org/10.14745/ccdr.v51i67a01
Keywords: viral hepatitis, hepatitis B, hepatitis C, prevalence, priority populations, immigrants

Introduction

Hepatitis B and C are viral infections that pose a significant health threat, as they have the potential to induce chronic liver infection, culminating in severe complications, such as cirrhosis and liver cancer. Recognizing the urgency of this public health challenge, the World Health Organization developed the *Global health sector strategies 2022–2030*, on HIV, viral hepatitis and sexually transmitted infections to guide focused responses by member states towards eliminating sexually transmitted and blood-borne infections (STBBI) by 2030 (1). Canada endorsed these global goals and developed the Government of Canada's STBBI action plan 2024–2030 (2), building upon commitments for implementing the pan-Canadian STBBI framework for action (3).

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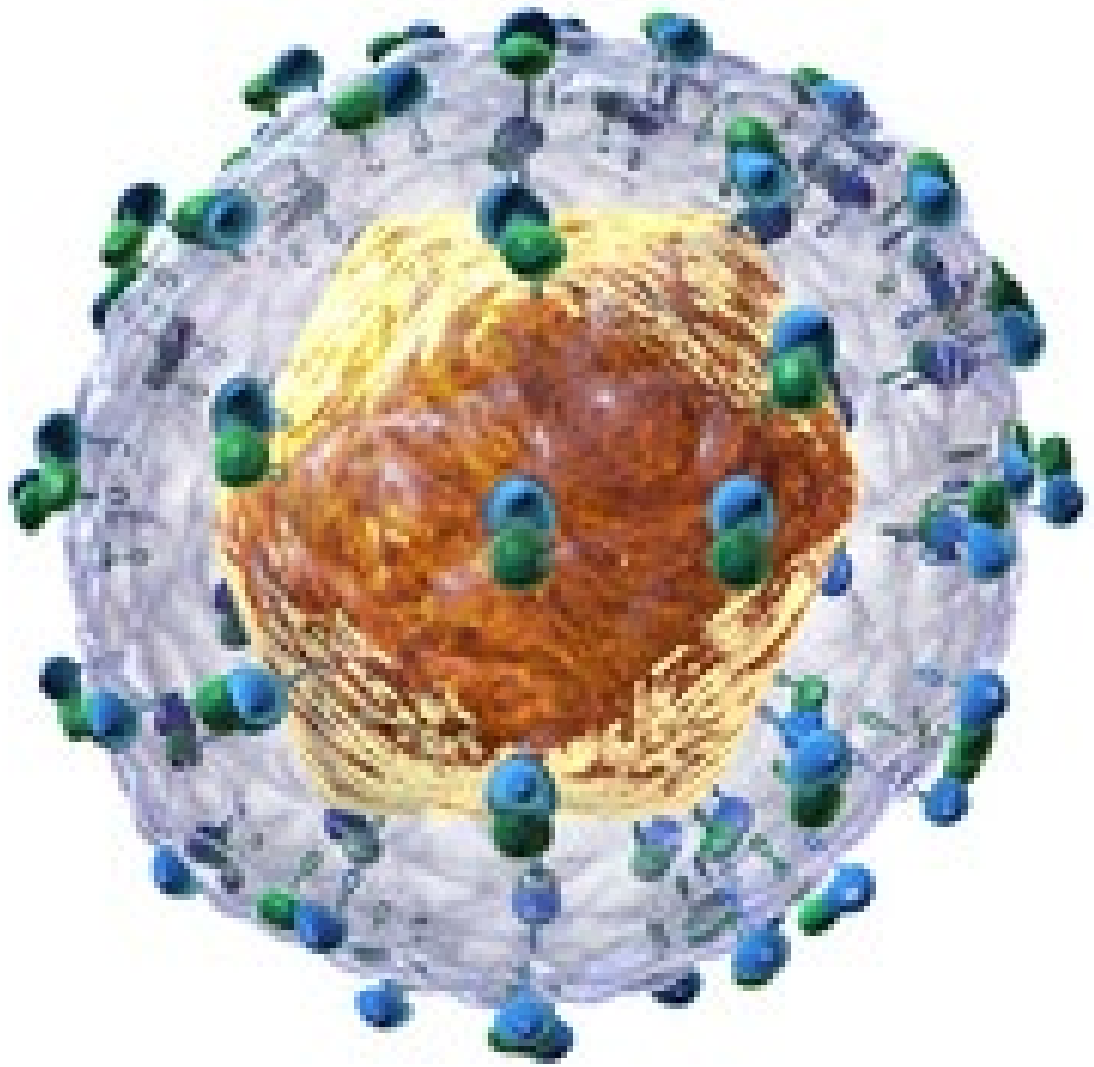
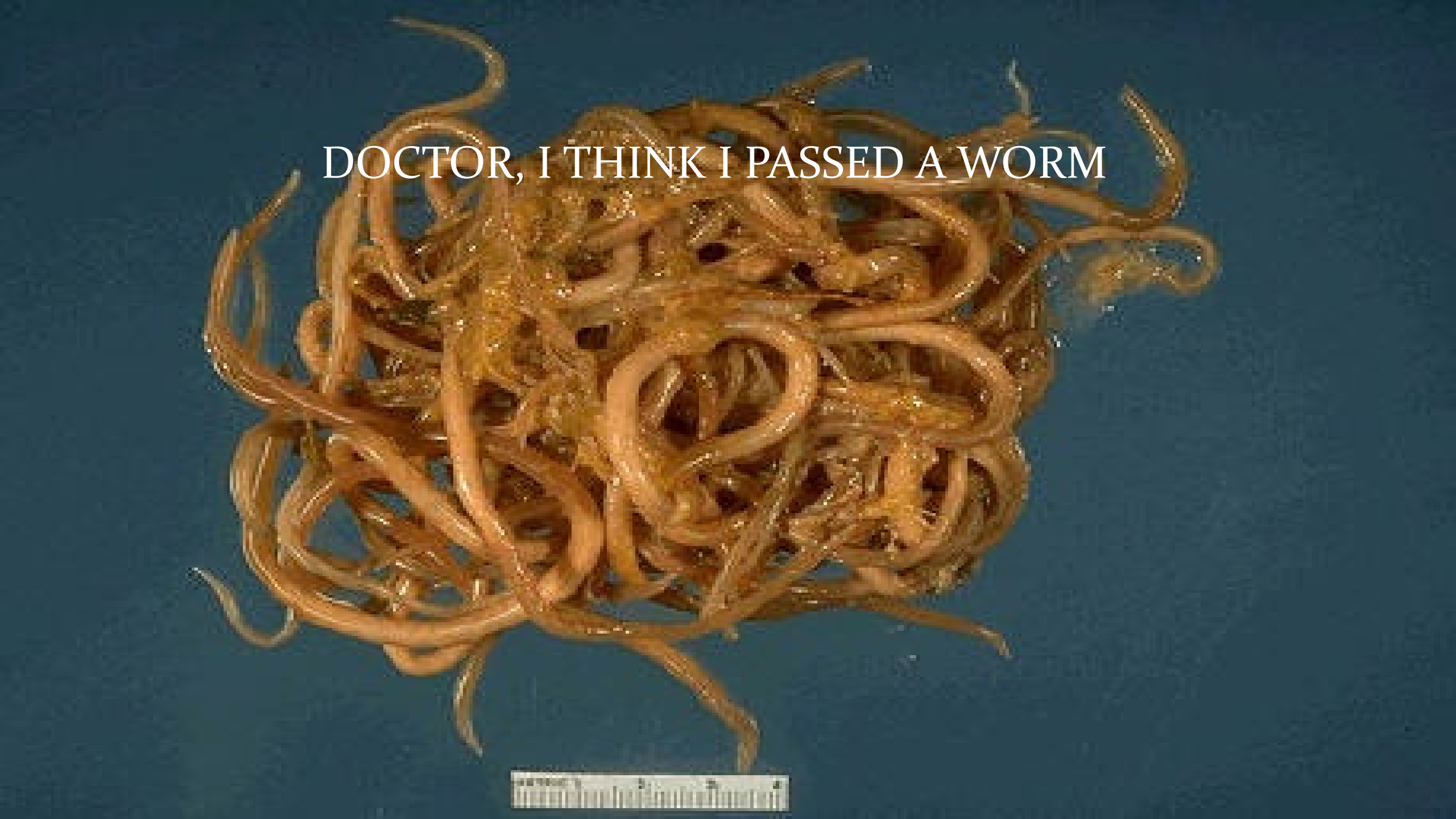


Hepatis C Virus (HCV)

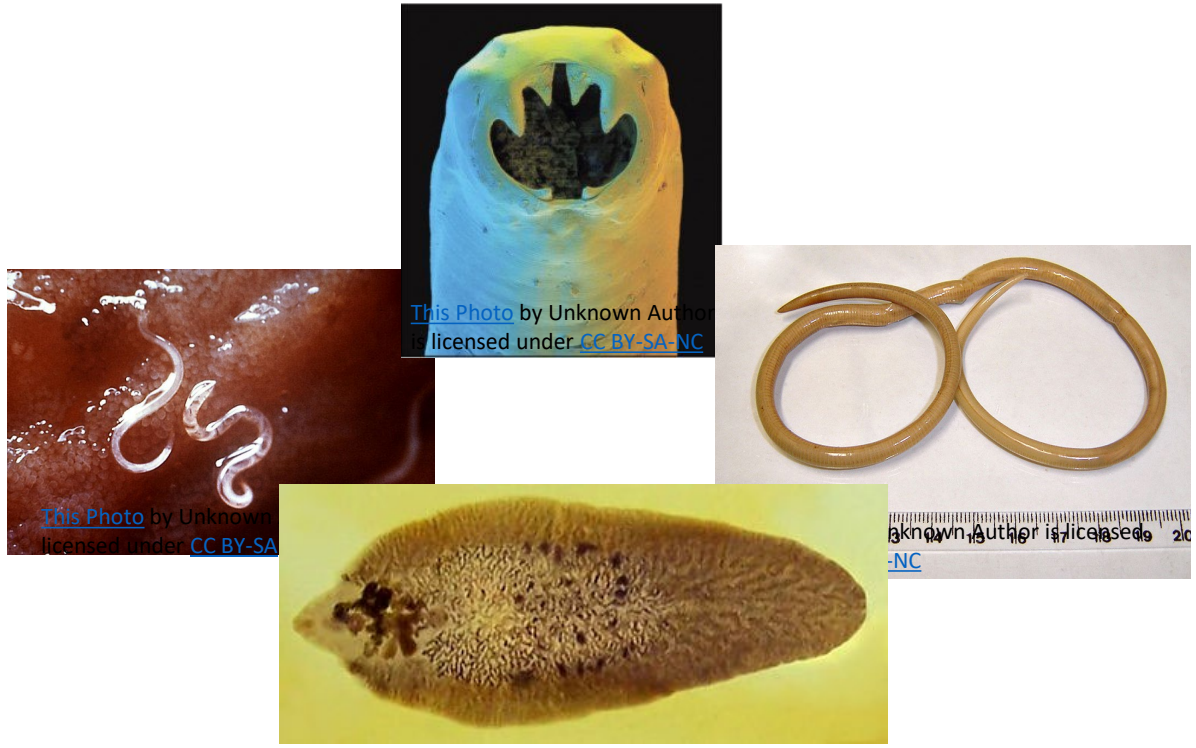
Hepatitis C

- One-time universal screening vs risk-based screening
- Increased burden in those coming from area of high prevalence
- May be higher in refugee populations
- Treatments are incredibly effective (lowers threshold for screening)

DOCTOR, I THINK I PASSED A WORM



What are the most common parasites in refugee populations and should we be screening for them?



Müller et al. BMC Infectious Diseases (2022) 22:249
https://doi.org/10.1186/s12879-022-07226-4

BMC Infectious Diseases

RESEARCH

Open Access

Intestinal parasites in stool testing among refugees at a primary care clinic in Toronto, Canada

Frank Müller[1,2*], Shivani Chandra[3], Isaac I. Bogoch[4,5], Meb Rashid[1,6] and Vanessa Redditt[1,3,6]

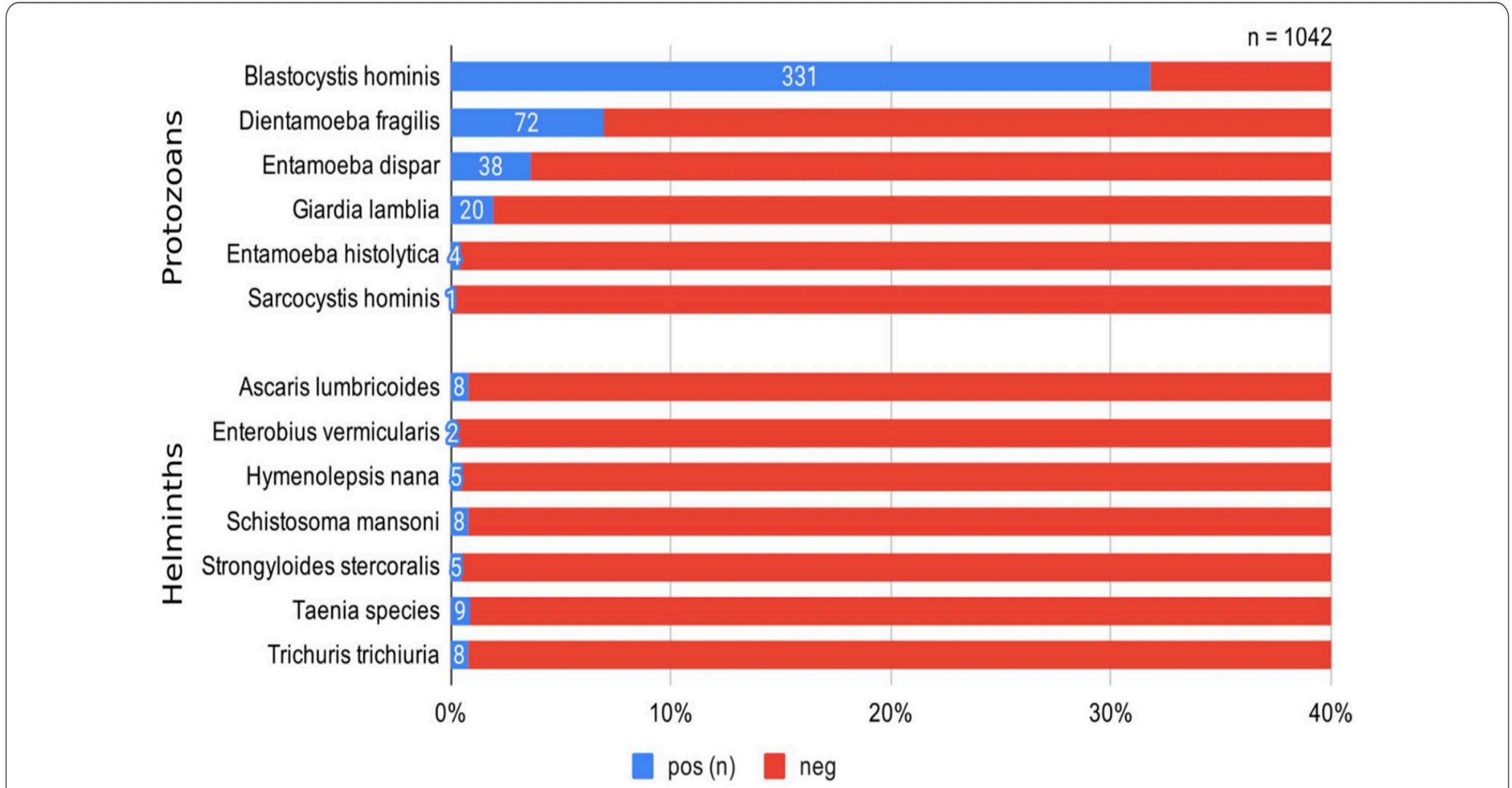


Fig. 2 Frequency of parasite organisms identified in patients' stool ova & parasite samples (n = 1042)

Public Health Implications?

Intestinal parasites in metropolitan Toronto day-care centres

J.S. KEYSTONE,* MD
J. YANG,* PH D
D. GRISDALE,* RN
M. HARRINGTON,* RT
L. PILLON*
R. ANDREYCHUK,† MD

In 1981, 900 children (aged 3 months to 10 years) and 146 staff attending 22 day-care centres in metropolitan Toronto chosen at random provided a stool specimen in a survey for intestinal parasites. Of the children, 4% to 36% were infected in 20 of 22 centres. Overall, 19% of the children and 14% of the staff had intestinal parasites: 8.6% and 4.0% respectively had *Dientamoeba fragilis*, and 7.8% and 2.0% respectively had *Giardia lamblia*. The highest prevalence of dientamebiasis was in the 7- to 10-year-olds, whereas giardiasis was detected most frequently in the 6-year-olds. Infection with intestinal parasites was not correlated with age, sex, duration in the day-care centre, dog ownership, travel history, gastrointestinal symptoms or the proportion of children in the day-care centre who were born in less developed countries. Immigrant children and children of parents born in industrialized countries (including Canada) were more likely to be infected than were children born in Canada of parents from the developing world. Dientamebiasis was associated with cat ownership. Thus, intestinal protozoa — in particular, *D. fragilis* and *G. lamblia* — are endemic in Toronto day-care centres.

En 1981, dans le cadre d'une étude sur les parasites intestinaux, on a prélevé un spécimen de selles de 900 enfants (âgés de 3 mois à 10 ans) et de 146 membres du personnel de 22 garderies, prises au hasard, du grand Toronto. Dans 20 des 22 centres étudiés, entre 4% et 36% des enfants étaient infectés. Au total, 19% des enfants et 14% du personnel avaient des parasites intestinaux: dans 8,6% et 4,0% des cas respectivement il s'agissait de *Dientamoeba fragilis*, et dans 7,8% et 2,0% des cas respectivement il s'agissait de *Giardia lamblia*. Les enfants âgés de 7 à 10 ans présentaient la plus haute prévalence de dientamibiase, alors que la giardiase se retrouvait le plus fréquemment chez les enfants âgés de 6 ans. Il n'y avait pas de relation entre l'infection parasitaire et l'âge, le sexe, la durée du séjour en garderie, la possession d'un chien, les antécédents de voyage, les symptômes gastrointestinaux ou la proportion d'enfants dans la garderie nés dans des pays en voie de développement. Les enfants immigrants et les enfants dont les parents sont nés dans des pays industrialisés (y compris le Canada) présentaient une plus grande tendance à l'infection que les enfants nés au Canada de parents venus de pays en voie de développement. On a constaté une corrélation entre la dientamibiase et la possession d'un chat. Les protozoaires intestinaux, en particulier *D. fragilis et G. lamblia*, se trouvent donc à l'état endémique dans les garderies de Toronto.

From *the Tropical Disease Unit, Toronto General Hospital and the departments of medicine and medical microbiology, University of Toronto, and †the Disease Control and Epidemiology Service, Ontario Ministry of Health, Toronto

Reprint requests to: Dr. J.S. Keystone, Tropical Disease Unit, Toronto General Hospital, 101 College St., Toronto, Ont. M5G 1L7

Recent expansion of day-care facilities has brought more children into close contact with one another outside the home and has been accompanied by increased transmission of enteric viral, bacterial and parasitic infections. Outbreaks of rotavirus infection, hepatitis A, salmonellosis, shigellosis and giardiasis in day-care centres have been reported recently.[1-7]

In 1977 Black and colleagues[5] reported person-to-person transmission of giardiasis in three day-care centres in Atlanta, Georgia. Soon after, outbreaks of giardiasis were reported in two day-care centres in Toronto.[6] With increased awareness of this problem, public health departments in metropolitan Toronto took a special interest in following up reported cases of giardiasis in day-care centres and by the end of 1979 had documented more than 12 "outbreaks". Whether the so-called outbreaks were an epidemic or a previously unrecognized endemic problem was not clear. To clarify the prevalence, clinical significance and epidemiology of intestinal parasites in day-care centres, in 1981 the Tropical Disease Unit, Toronto General Hospital, in conjunction with the Disease Control and Epidemiology Service of the Ontario Ministry of Health, conducted a survey for intestinal parasites in day-care centres in Toronto.

Method

Using random-number tables, we selected centres from a list of 376 day-care centres that served the population of metropolitan Toronto. Of the 30 chosen, 22 agreed to participate. All children and staff were asked to complete a questionnaire and to provide a single stool specimen preserved in sodium acetate formalin.[8] Informed consent was obtained from all participants or their guardians.

The stools were processed in the Tropical Disease Unit laboratory by the formalin–ether concentration

Intestinal parasites in metropolitan Toronto day-care centres

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22 day care centres in Toronto in 1984
19% of children and 14% of staff had intestinal parasite
8.6% had D. fragilis and 7.8% had Giardia

***Treatment did **not** lead to eradication*

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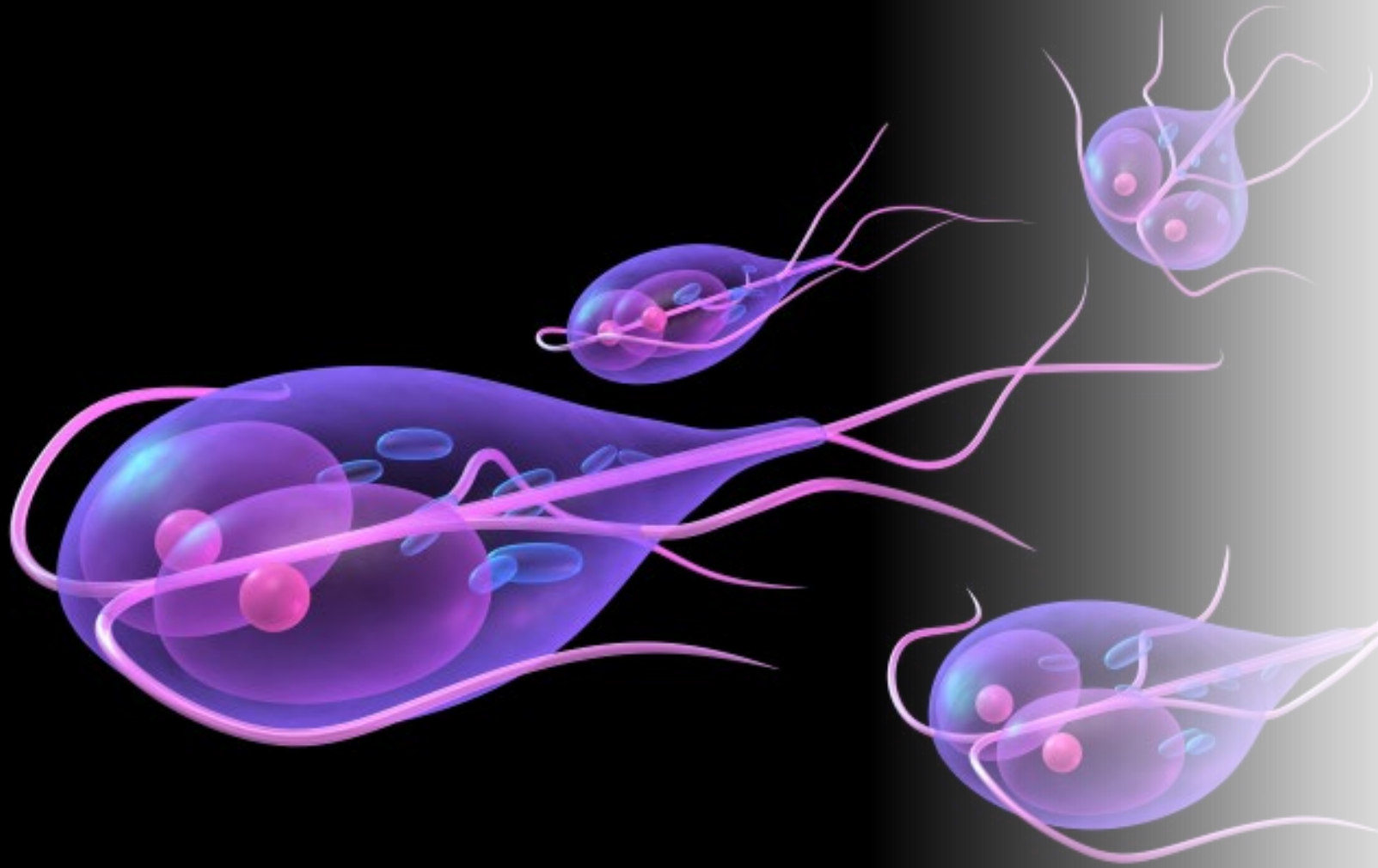


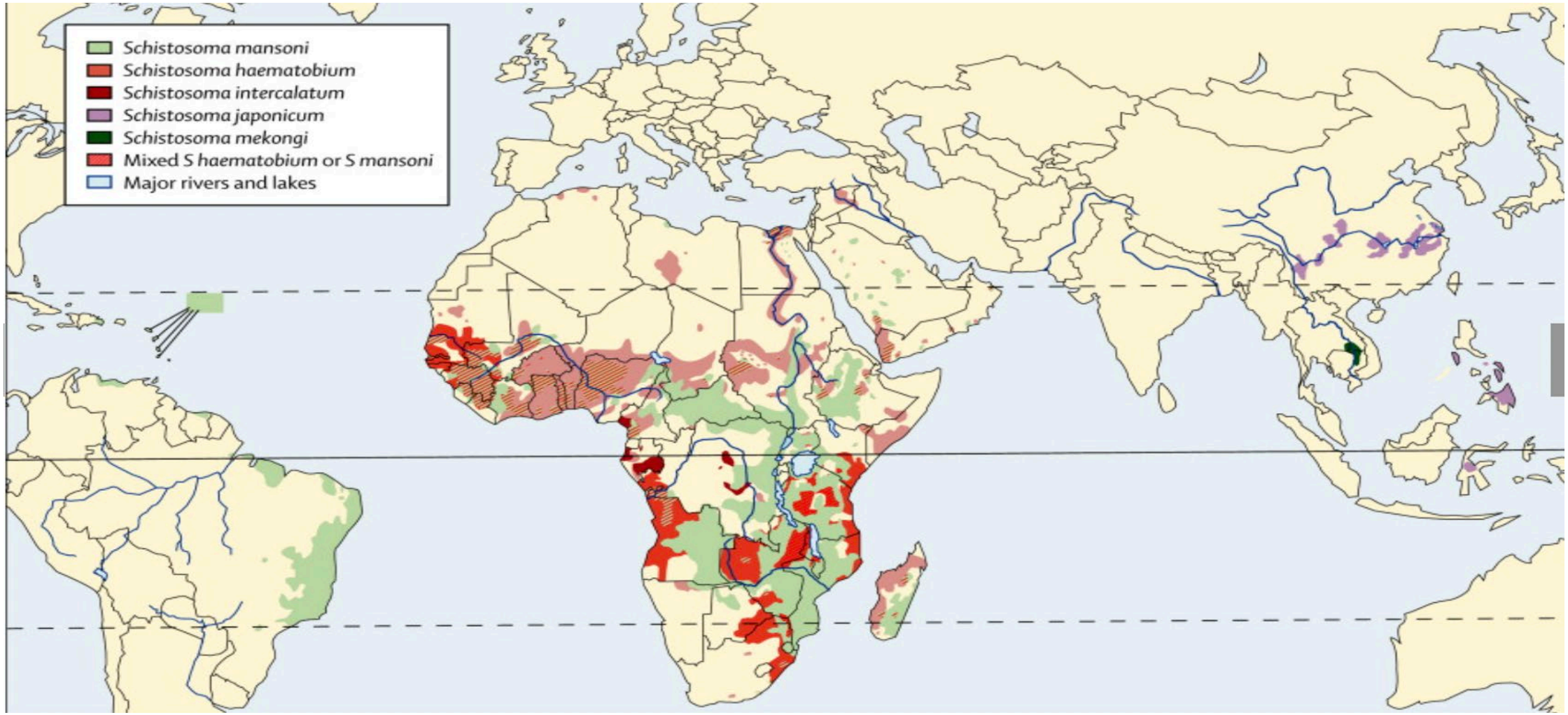
Don’t forget those that are symptomatic!

- Abdominal pain-upper and lower
- Chronic diarrhea
- Iron deficiency anemia
- Children who have short stature or have low weight for age
- Unexplained eosinophilia

Schistosomiasis

- Infects 200-500 million people globally
- Three major strains:
  - Two infect mesenteric vasculature (eggs in stools)
    - S. mansoni and S. japonicum
  - One infects vascular plexus of bladder (eggs in urine)
    - S. haematobium
- Common cause of liver failure, hematuria
- Check serology (note distinguish if current or resolved infection)
- Check UA to ensure no microscopic hematuria (if from SSA)

Global Schistosomiasis Distribution



Source: Human schistosomiasis. Colley DG, Bustinduy AL, Secor WE, King CH. Lancet. 2014 Jun 28;383(9936):2253-64. doi: 10.1016/S0140-6736(13)61949-2. Epub 2014 Apr 1. PMID: 24698483

Strongyloides

- Persistent infections
- Often asymptomatic or mild GI symptoms
- Eosinophilia not sensitive
- Disseminated Strongyloides Infection when immunosuppressed (70% CFR)
- Need to rule out Loa Loa before using ivermectin in some pts
- Test for HTLV1 if positive serology

Is there a rationale to screen for enteric parasites among asymptomatic refugees?

- Strongyloides and Schistosomiasis are exceptions
- Is the person truly asymptomatic?
- What to do with eosinophilia?

LTBI

- Who to screen?
- Screen and rx those that are likely to develop active TB
- Risk of reactivation is based on country of origin, length of time in Canada, immigration category and comorbidities

Table 2. Risk of TB disease and the incidence rate ratio of TB disease among different populations stratified by risk

Risk factor	Annual risk of TB disease for the first 2-3 years after testing positive (%) [a]	Reference
Very high risk		
People living with HIV	1.7 to 2.7	2 56
Child or adolescent (<18y) tuberculosis contact	2.9 to 14.6	56 57
Adult (≥18y) tuberculosis contact	0.8 to 3.7	2 56
Silicosis	3.7	2
High risk		
Stage 4 or 5 chronic kidney disease with or without dialysis	0.3 to 1.2	2
Transplant recipients (solid organ or hematopoietic)	0.1 to 0.7	2
Fibronodular disease	0.2 to 0.6	extrapolated from: 75 76 77
Receiving immunosuppressing drugs (e.g., tumor necrosis factor α inhibitors or steroids) [b]	0.5	2
Cancer (lung, sarcoma, leukemia, lymphoma or gastrointestinal)	0.1 to 0.4	extrapolated from: 70
Moderate risk		
Granuloma on chest x-ray	0.1	extrapolated from: 77 78
Diabetes	0.1 to 0.2	extrapolated from: 83
Heavy alcohol use (at least 3 drinks/day)	0.1 to 0.2	extrapolated from: 79
Heavy tobacco cigarette smoker (at least 1 pack/day)	0.1	extrapolated from: 80 81 82
Low risk		
General (adult) population with no known risk factor	0.03	2
Persons with a positive two-step TST booster and no known risk factor	0.02	extrapolated from: 84 85

Abbreviations:
HIV, human immunodeficiency virus; TST, tuberculin skin test.

Footnotes:

[a] Risks are expected to halve after this period and continue to decrease subsequently.

Canadian TB Standards: Summary of TBI recommendations

Risk of developing active TB	Age	TB incidence in country of origin		
		<50	50-200	>200
Very high risk*	All ages	Yes	Yes	Yes
High risk*	≤65	No	Yes	Yes
	>65	No	Consider	Consider
Low/Moderate risk*	≤65	No	Consider	Consider‡
	>65	No	Consider	Consider
Refugees†	≤65	No	Yes	Yes
	>65	No	Consider	Consider

*__Very high risk__ e.g. HIV, TB contacts, silicosis;
__High risk__ e.g. advanced CKD ± dialysis, solid/hematologic transplantation, immunosuppressive drugs, active cancer;
__Moderate risk__ e.g. diabetes, heavy tobacco, heavy ETOH; __low risk__ no risk factors
† __Refugees__ within two years of arrival, ‡ Within 5 years of arrival

Canadian TB Standards 8th Edition 2022. Greenaway et al. Chapter 13. TB surveillance and TB infection testing and treatment in migrants

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Canadian TB Standards 8th Edition 2022. Greenaway et al. Chapter 13. TB surveillance and TB infection testing and treatment in migrants

Country
Group

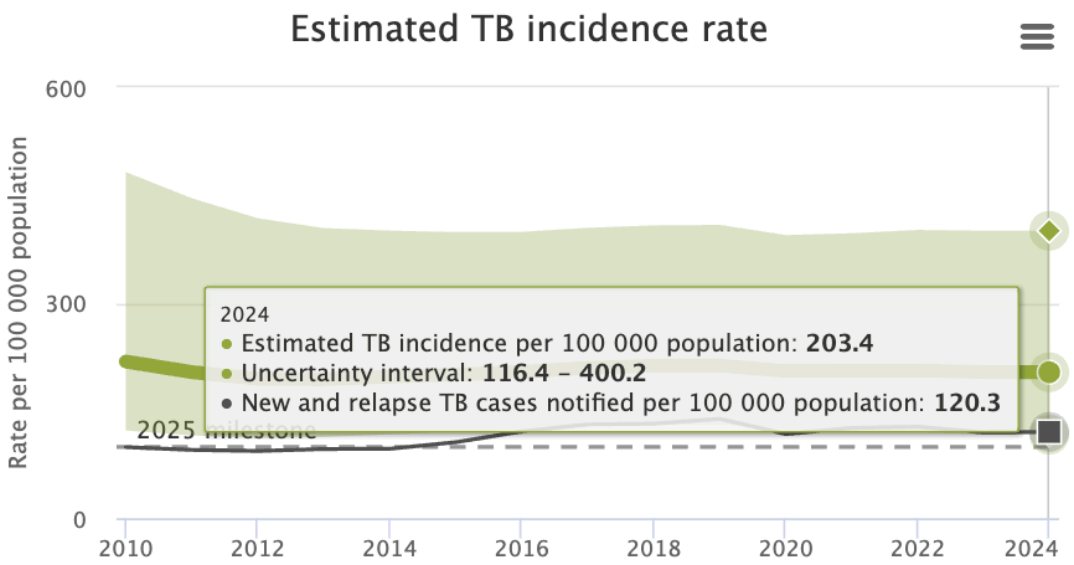
Afghanistan

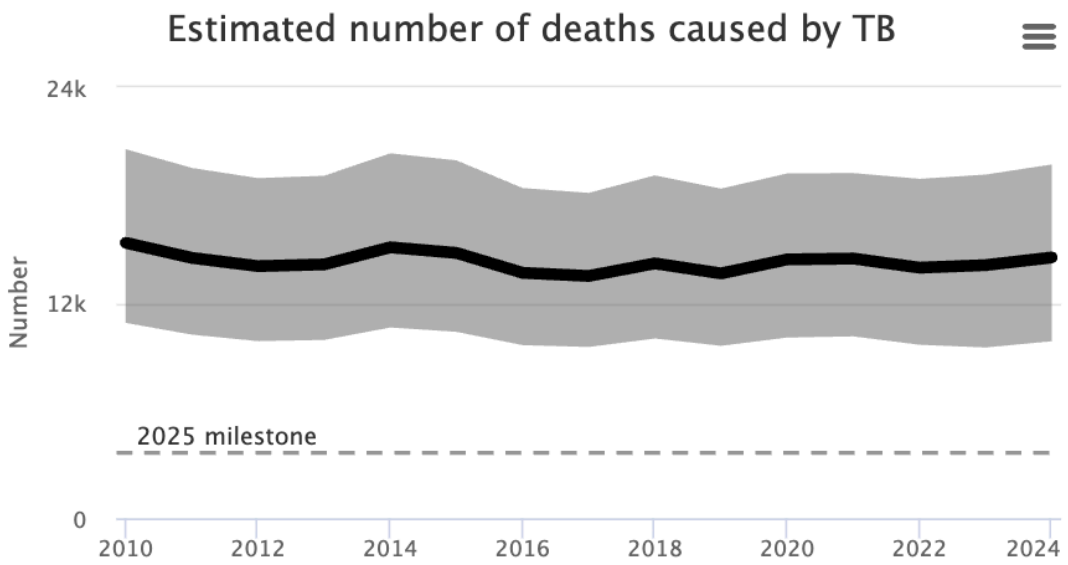
English Español Français Русский

Tuberculosis profile: Afghanistan

Data last updated: 2025-10-10

CHARTS DATA TABLES





General Approach to Immunization in Immigrants

What happens in primary care?

-Children are immunized with age appropriate immunizations

-catch up immunizations are an issue

-Likely could be doing better with adult immunizations

Our Screening of Asymptomatic Refugees

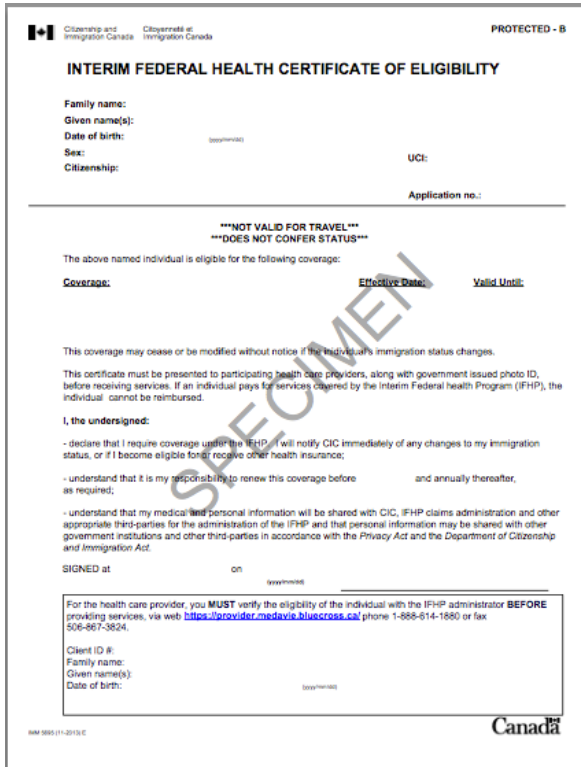
- CBC
- HBsAg/HBsAb/HBcAb
- Hepatitis C
- Syphilis*
- HIV*
- Varicella serology (over 13y.o.)
- Serology for schistosomiasis and strongyloides
- lead levels in children (<7y.o.)
- Tuberculin skin tests (one day IGRA's?)
- Immunizations
- Hb electrophoresis
- Immunizations
- Chagas disease (Latin Americas)
- Age appropriate cancer and chronic disease screening

Health Insurance

- Refugee claimants-Interim Federal Health Program
- Privately Sponsored and Government Assisted Refugees-OHIP and IFH

Health Insurance for Refugees

- Show Interim Federal Health Program Certificate
- Health professionals must be registered with IFHP Medavie Blue Cross



Current Status of the Interim Federal Health Program

All those with valid IFH certificates have coverage for

- a) MD visits/diagnostic tests/laboratory tests
- b) for supplemental services

IFHP Supplemental Coverage

- **Medications:** Similar to Ontario Drug Benefit (ODB) formulary
- **Dental:** Emergency exams, x-rays, extractions
- **Vision:** Annual eye exam and glasses/lenses every 2 years
- **Allied health** professional services: physical therapy, occupational therapy, speech & language, nursing visits, clinical psychologists
- **Medical devices** and equipment

Benefit grid: https://provider.medavie.bluecross.ca


“Today, as yesterday, a nation is judged by its attitude towards refugees.”
Elie Wiesel, Nobel laureate

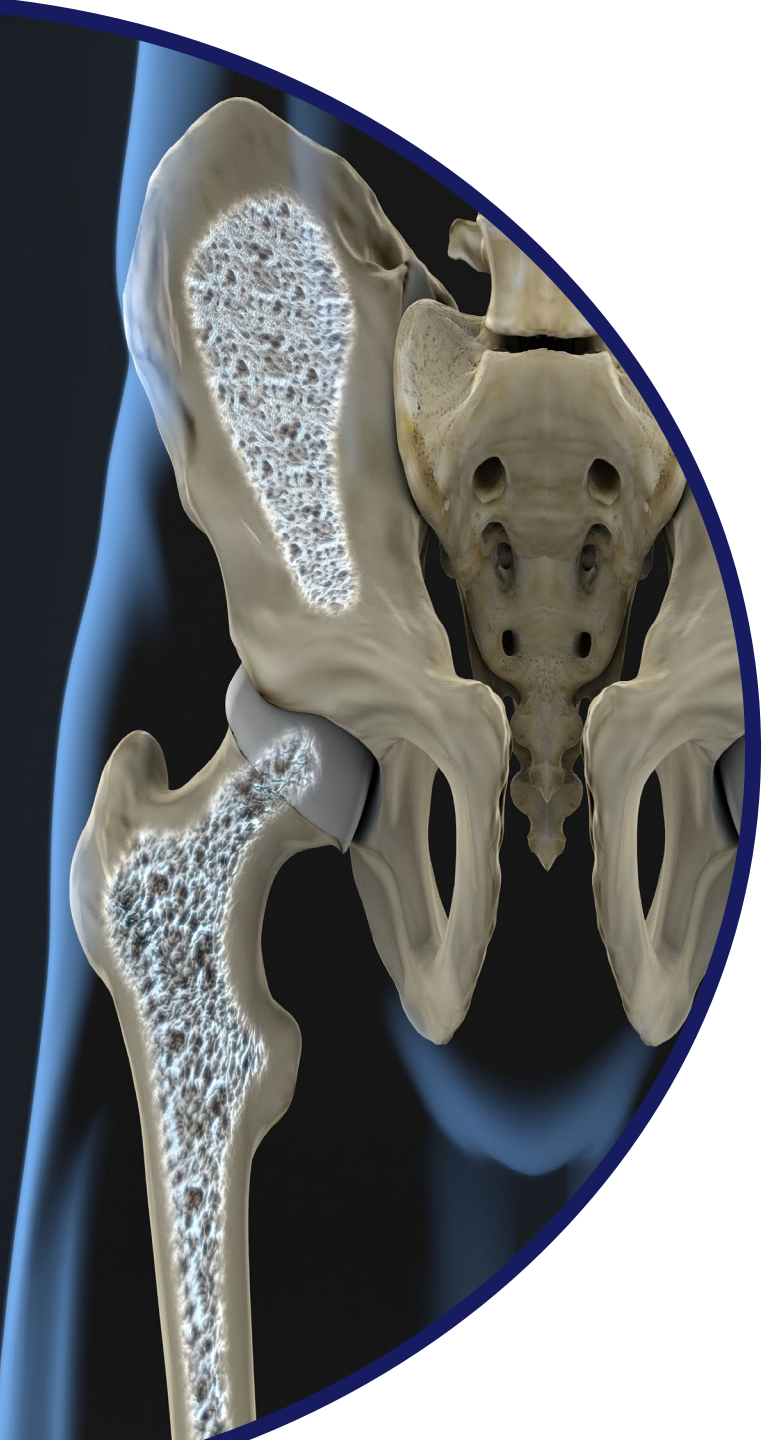
Next Health Equity CoP: Coming in Early 2026

- **Topic:** TBD
- **Date:** Early 2026
- Attendees will receive an email notification once registration launches in 2026. Stay tuned for more details!

We'd love your input!

The Health Equity CoP was developed to enhance the ability of family physicians to provide high-quality care to patients **facing marginalization and adverse social determinants of health**, such as refugee newcomers, people living in poverty and people experiencing homelessness.

What topics would you like us to cover in this upcoming session?



Ontario College of Family Physicians

ONTARIO Osteoporosis Strategy

Osteoporosis and Fracture Prevention Workshop

Don't miss this last opportunity to earn 3 Mainpro+ credits per hour (9 total)

Join us to:

- **Save Time and Get Clarity:** Understand the latest guidelines with experts to answer your questions.
- **Immediate Practice Application:** Discover practical, evidence-based strategies for family medicine you can readily use.
- **Confident Patient Management:** Gain a deeper understanding of medications and exercises to improve outcomes and discuss osteoporosis management.

December 3, 2025 | 12:00PM-3:00PM
$195 + HST

Register Today!

Scan to learn more

Upcoming Changing the Way We Work Community of Practice

Infectious Disease & Current Public Health Issues
with Drs. Daniel Warshafsky & Kieran Moore

100th session!

December 5, 2025
8:00am – 9:00am

Register Now

The Changing the Way We Work Community of Practice for Ontario Family Physicians is a one-credit-per-hour Group Learning program that has been certified for up to a total of 32 credits.

Psychedelics and the Use in Treatment of Mental Health

Join our upcoming Community of Practice!

Wednesday, December 10
8:00 am – 9:00am

Interest in psychedelics for treating PTSD, depression, and substance use disorders is growing. Patients may ask about these options, but many family physicians lack up-to-date knowledge on safety, efficacy, and available services in Ontario.

Our panel will:

- Provide a general overview of psychedelics
- Share personal experiences treating patients in clinic
- Discuss the referral process and more

Register Today

UPCOMING!

Public Health Ontario | Santé publique Ontario

Ontario College of Family Physicians

Antimicrobial Stewardship in Primary Care
Audit and Feedback to Improve Antibiotic Prescribing

January 16, 2026
12:00 p.m.to 1:00 p.m.

FREE

Register Now!

Early Years and Resident Survey

Survey 1: Supporting Early-Career Family Physicians

OCFP is gathering insights to **better support members in their first five years** of practice
Your feedback will help develop: Practical tools and resources and knowledge translation materials.

Scan to complete Early-Career Survey

Survey 2: Supporting Family Medicine Residents

OCFP is gathering insights to support residents as they **transition into practice**
Your feedback will help: Improve the Transition to Practice Guide, develop practical tools and resources and offer educational content that meets your needs.

Scan to complete Resident Survey

Details for Both Surveys

Deadline: Friday, December 12 at 5:00 PM
Time to complete: Less than 10 minutes
Upon survey completion: Enter a draw for a **$200 Amazon.ca gift card**