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| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Last First Middle  **Passport Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Passport Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Authorizing physician: \_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Required Immunizations and Testing** | | |
| **Tetanus-Diphtheria Acellular Pertussis (Tdap)**  **Requirement:**    **1 dose of vaccine above age 18 years** | | Tdap Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Polio**  **Requirement:**    **1 dose of vaccine above age 18 years** | | Polio Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Measles-Mumps-Rubella (MMR)**  **Requirement:**  Measles 2 doses of vaccine or positive titer  Mumps 2 doses of vaccine or positive titer  Rubella 2 dose of vaccine or positive titer | | MMR Dose 1: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  MMR Dose 2: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  OR  Measles Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Mumps Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Rubella Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  **Please attach the results** |
| **Hepatitis B Vaccine (Hep B)**  **Requirement:**  --Hepatitis B QUANTITATIVE Surface Antibody after three doses of vaccine  **Please attach the result** | | Hepatitis B Dose 1: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Hepatitis B Dose 2: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Hepatitis B Dose 3: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  **AND**  **(REQUIRED)**  Hepatitis B Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Varicella (Chickenpox) Vaccine**  **Requirement:**  2 doses of vaccine or positive antibody titer or declaration of past infection | | Varicella Dose 1: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Varicella Dose 2: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  **OR**  Varicella Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_    **Please attach the result**  **OR**  Past Infection declaration Yes/No |
| **Tuberculosis Screening (PPD or TST testing)**  (Hospital Health Services reserves the right to request additional documentation and/or testing) | **No previous TST:** Complete two TSTs at least one week apart within 24 months of your start date | PPD 1: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ result \_\_\_\_\_\_\_\_\_  PPD 2: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ result \_\_\_\_\_\_\_\_\_  **OR**    IGRA \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  (QuantiFERON)  **OR**    CXR \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  INH Start Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  **TO**  INH Stop Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  **Please attach the result** |
| **Last TST was performed prior to 24 months of start date**  Perform one additional TST and supply documented copy of this TST plus a copy of results of two TSTs prior to latest test. |
| **Prior History of positive TST, IGRA or Tuberculosis:**  Provide documentation of positive test results, medication and/or treatment as well as a chest X-ray report |
| **Required HCV antibodies within last 12 months of start date Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: Positive/Negative**  **Please attach the result** | | |