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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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ ORMeasles 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**  |