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| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last First Middle  **Social Security Number:** \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  **Address:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street City, State Zip Code  **Day Telephone**: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **In addition to completing this form, you MUST upload it and all supporting documentation to the MedHub site.** |

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| **Required Immunizations and Testing** | | |
| **Tetanus-Diphtheria Acellular Pertussis (Tdap)**  **Requirement:**    1 dose of vaccine within last 10 years. | | Tdap Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Measles-Mumps-Rubella (MMR)**  **Requirement:**  Measles 2 doses of vaccine or positive titer  Mumps 2 doses of vaccine or positive titer  Rubella 1 dose of vaccine or positive titer | | MMR Dose 1: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  MMR Dose 2: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  OR  Measles Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Mumps Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Rubella Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Hepatitis B Vaccine (Hep B)**  **Requirement:**  --Hepatitis B QUANITATIVE Surface Antibody after three doses of vaccine | | 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 | | Varicella Dose 1: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Varicella Dose 2: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  **OR**  Varicella Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Tuberculosis Screening (PPD or TST testing)**  (Campus Health Services reserves the right to request additional documentation and/or testing) | **No previous TST or your last TST was more than 14 months ago regardless of BCG history:** Complete two TSTs at least one week apart within 6 months of your start date | PPD 1: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  PPD 2: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  **OR**    IGRA \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  (Quantiferon or T Spot)  **OR**    CXR (within 60 days of start) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  INH Start Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  **TO**  INH Stop Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Last TST was performed within 14 months of start date**  Complete TST within 6 months prior to start date and supply copy of TST immediately prior to most recent TST. |
| **Prior History of positive TST, IGRA or Tuberculosis:**  1. Provide documentation of positive test results, medication and/or treatment as well as a chest X-ray report **within 60 days of your start date.**  2. If you received the BCG vaccine and your first or second TST positive you will need to obtain an IGRA blood test.  3. Complete TB Questionnaire (TBQ) upon starting and annually thereafter |
| **Respirator Fit Testing** | Fit testing for 3M 1860 or 1860S N95 respirator within 3 months of residency start date.  CHECK WITH YOUR RESIDENCY COORDINATOR FOR SCHEDULING | Fit Testing: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |