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