UofL Campus Health Services
Immunization Program
Health Sciences Center
502-852-2708

Immunization Compliance Form for Graduate Medical Education Programs

Name: _____ **DOB:** _____/_____/_____
Last First Middle

Day Telephone: (_____) _____ **Email:** _____@_____

Residency/Fellowship Program Name: _____

In addition to completing this form, you MUST upload it and all supporting documentation to the MedHub site.

Required Immunizations and Testing

Tetanus-Diphtheria Acellular Pertussis (Tdap) **Requirement**: 1 Dose of vaccine within the 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 90 days of your start date **Last TST was performed within 14 months of start date** Complete TST within 90 days 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	PPD 1: _____/_____/_____ PPD 2: _____/_____/_____ **OR** IGRA (Quantiferon or T Spot) _____/_____/_____ **OR** CXR (within 60 days of start) _____/_____/_____ INH Start Date: _____/_____/_____ TO INH Stop Date _____/_____/_____
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: _____/_____/_____
Covid-19 Vaccination	2 doses of Pfizer/Moderna Vaccine **OR** 1 dose J&J Vaccine *Covid-19 Booster vaccinations are highly recommended.*	Covid-19 Dose 1: ____/____/_____ Covid-19 Dose 2: ____/____/_____ Covid-19 Booster ____/____/_____