**Immunization and Tuberculosis (TB) Screening Record**

**This information is required at the time of application and all of the following information must be completed and signed by a health care provider.**

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| **Name** | **:** |  |
| **Date of Birth(YY/MM/DD)** | **:** |  |
| **Nationality** | **:** |  |
| **E-mail Address** | **:** |  |
| **Medical School** | **:** |  |

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| **Measles / mumps / rubella** | **□ Completed two doses of MMR vaccine**Date #1: / / / (YY/MM/DD)Date #2: / / / (YY/MM/DD)**OR** **□ Completed two doses of individual vaccines**Measles vaccine Date #1: / / / (YY/MM/DD)Date #2: / / / (YY/MM/DD)Mumps vaccineDate #1: / / / (YY/MM/DD)Date #2: / / / (YY/MM/DD)Rubella vaccineDate: / / / (YY/MM/DD)**OR** **□ Positive blood titers**Measles titer date: / / / (YY/MM/DD)Mumps titer date: / / / (YY/MM/DD)Rubella titer date: / / / (YY/MM/DD)  |
| **Varicella** | **□ History of varicella disease (verified by physician)**Date: / / / (YY/MM/DD)**OR** **□ Positive blood titer**Date: / / / (YY/MM/DD)**OR** **□ Completed two doses of varicella vaccine**Date #1: / / / (YY/MM/DD)Date #2: / / / (YY/MM/DD) |
| **Hepatitis B** | **□ Completed three doses of hepatitis B vaccine**Date #1: / / / (YY/MM/DD)Date #2: / / / (YY/MM/DD)Date #3: / / / (YY/MM/DD)**OR** **□ Positive hepatitis B antibody titer** Date: / / / (YY/MM/DD) |
| **Hepatitis A** | **□ Completed two doses of hepatitis A vaccine** Date #1: / / / (YY/MM/DD)Date #2: / / / (YY/MM/DD) |
| **TB screening** | **□ Tuberculin skin test** Date: / / / (YY/MM/DD) Result: mm, □ Negative □ Positive**OR** **□ Interferon gamma release assay (IGRA) test**Date: / / / (YY/MM/DD) Result: □ Negative □ Positive  |
| **□ Chest X-ray (within the last six months)**Date: / / / (YY/MM/DD) Result:  |
| **If TB skin test or IGRA is positive and/or chest X-ray is abnormal, please complete TB questionnaire.** |

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| **Verification of the above immunization and TB screening record by healthcare provider** |
| **Authorized Signature** | **:** |  |
| **Date(YY/MM/DD)** | **:** |  |
| **Printed Name** | **:** |  |
| **Title** | **:** |  |
| **Name of Hospital/Institution** | **:** |  |
| **Address** | **:** |  |
|  |  |  |
| **Phone** | **:** |  |
| **E-mail address** |  |  |
| **Official Stamp or Seal** | **:** |  |