**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 vaccine  Date #1: / / / (YY/MM/DD)  Date #2: / / / (YY/MM/DD)  Rubella vaccine  Date: / / / (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** | **:** |  |