2024

Baylor College of Medicine

Occupational Health Program

INCOMING RESIDENT/FELLOW IMMUNIZATION RECORD

Name _____ Date of Birth_____ Phone_____

Residency/Fellowship Program_____ Email _____

Complete form and ATTACH SUPPORTING DOCUMENTATION

	DATE
A. **Tetanus-Diphtheria-Pertussis (Tdap)-** Td is not acceptable 1. _____Tdap booster within the last 10 years. (attach record)	_____ _____
B. **M.M.R. (Measles, Mumps, Rubella)** (please document each dose) 1. _____Dose 1: Immunized at 12 months or after. (attach record). 2. _____Dose 2: Immunized at least 1 month after dose 1 (attach record).	_____ _____
C. **Measles (Rubeola)** - If given instead of M.M.R. check appropriate item 1. _____Serologic proof of immunity. (attach record). Or, 2. _____Two doses of vaccine, on or after first birthday. (attach records)	_____ _____
D. **Mumps** - If given instead of M.M.R. check appropriate item 1. _____Serologic proof of immunity. (attach record). Or, 2. _____Two doses of vaccine, on or after first birthday. (attach records)	_____ _____
E. **Rubella** - If given instead of M.M.R. check appropriate item 1. _____Serologic proof of immunity. (attach record). Or, 2. _____Two doses of vaccine, on or after first birthday. (attach records)	_____ _____
F. **Varicella (Chickenpox)-** History of disease is not acceptable 1. _____Serologic proof of immunity. (attach record). Or, 2. _____Two doses of vaccine (attach record).	_____ _____
G. **Hepatitis B** –provide documentation for all administered shots 1. _____Serologic proof of immunity. (attach record). Or, 2. _____Immunization (at least 3 doses and attach records)	_____ _____ _____ _____
H. **Tuberculosis** 1. _____IGRA blood test done within 6 months prior to your start date. (attach record) 2. _____Had BCG vaccine. If yes, IGRA blood test still has to be done. 3. _____If ever positive, provide record. Chest x-ray done within a year prior to your start date is required. Provide copy of x-ray report.	_____ _____ _____
I. **OHP Forms** 1. _____ TB Respirator Questionnaire. 2. _____ Acknowledgment of Receipt of Privacy Notice. The “HIPAA” form.	

PLEASE SUBMIT ALL RECORDS THROUGH MEDHUB

12/14/2023