



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