Immunization Form for Observers

Full Name (please print _____

Hospital Department ___Neurosurgery_____

Observership Start Date _____ Date of Birth_____
Gender (circle) M F

Signature_____

Type of Immunization

Type of Immunization or Health Care	Where Immunization or Test was Obtained	Date	Test Documenta-tion Attached * (Yes/No)	Health Care Provider Signature
TB Skin Test** (record result in millimeters)				
MMR Dose #1 (or record positive titers for Measles and Rubella)				
MMR Dose #2 (or record positive titers)				
Tetanus-Diphtheria (within past 10 years)				
Hepatitis B Vaccine Dose #1				
Hepatitis Dose #2				
Hepatitis Dose #3 (record titer if available)				

Influenza/ Flu Vaccination (Required when visiting between October to April)				

Please answer/complete the following questions:

1. Have you ever had chickenpox****? (circle one) YES NO

If so, when did you have chickenpox (or how old were you)? _____(year or age)

2. Have you ever had a blood test to prove chickenpox immunity or have you received chickenpox

immunizations? (circle one) YES NO

If so, please attach documentation of immunity or immunizations.

3. Do you give direct patient care or do you come in direct contact with patients, specimens or soiled

equipment? (circle one) YES NO

I understand that being hired and continued employment depends on the truthfulness of

this information.

Physician/ Health care provider signature_____Date_____

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* Definition of “documentation” – photocopy of your medical record signed by your health provider.

** If this test is positive or past tests have been positive, a copy of the result of your most recent chest X-ray is required.

*** Dates of immunizations for Hepatitis B vaccine and Tetanus-Diphtheria are sufficient documentation.

**** Hospital policy requires that patient care employees be immune to chickenpox, e.g., report past disease or receive immunization (unless it is medically contraindicated). If you are susceptible to chickenpox, you may not work in high risk