Universitätsklinikum Carl Gustav Carus

IMMUNIZATION VERIFICATION FORM

Dear Student, Doctor or Employee,

As you will be studying/ working in a clinical setting in the hospital, please provide the following information with respect to your immune status **together with your application documents/ vaccination card**.
This is required of all applicants.
A completely filled out Immunization/ Serology Record Form is required, otherwise you will not be allowed to work or study at our University Hospital.
The form can be completed and signed by either your general practitioner or by the occupation health department in the hospital where you are currently working or studying.

Surname: _____ **First Name(s):** _____

Date of Birth: _____

Address: _____

E-mail Address: _____ **Phone Number:** _____

Immunization against **Hepatitis B**: Date of 1st vaccination: _____
Date of 2nd vaccination: _____
Date of 3rd vaccination: _____

and Anti **Hepatitis B** Antibodies (**within the last 10 years and above 100 IU/l**):
Date: _____ Result: _____

Anti **Hepatitis C** Antibodies: ☐positive ☐negative Date: _____

Anti **Hepatitis A** Antibodies: ☐positive ***or*** Date of 1st vaccination: _____
Date of 2nd vaccination: _____

Anti **Measles** Antibodies (IgG): ☐positive ***or*** Date of 1st vaccination: _____
Date of 2nd vaccination: _____

Anti **Mumps** Antibodies (IgG): ☐positive ***or*** Date of 1st vaccination: _____
Date of 2nd vaccination: _____

Anti **Rubella** Antibodies (IgG): ☐positive ***or*** Date of 1st vaccination: _____
Date of 2nd vaccination: _____

or Date of 1st triple vaccination **(Measles/ Mumps/ Rubella)**: _____
Date of 2nd triple vaccination **(Measles/ Mumps/ Rubella)**: _____

Stand: 19.06.2017

Surname: _____ **First Name(s):** _____

Date of Birth: _____

Anti **Varicella** Antibodies (IgG): ☐positive ***or*** Date of 1st vaccination: _____
Date of 2nd vaccination: _____

or ☐ previous infection with varicella

Tetanus (to be renewed every 10 years): Date of vaccination: _____

Diphtheria (to be renewed every 10 years): Date of vaccination: _____

Pertussis (to be renewed every 10 years): Date of vaccination: _____

Poliomyelitis (to be renewed every 10 years): Date of vaccination: _____

or Date of quadruple vaccination **(Tetanus/ Diphtheria/ Pertussis/ Poliomyelitis)**:

Signature of Doctor: Place and Date:

Print Name: Stamp:

The following must be completed by the health service:

- ☐ a sufficient vaccination status is appropriate to the intended field of application
- ☐ a sufficient vaccination status is NOT appropriate to the intended field of application

  (for the following reasons _____)

_____

Place and date, stamp, signature of the occupational health medicine and healthcare