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)**: _________________

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**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**



Stand: 19.06.2017