**IMMUNIZATION VERIFICATION FORM (INTERNATIONAL TRAINEE)**

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| Last/Family Name: | First/Given Name: |
| Date of Birth: | Sex: |
| Passport Number: | Nation: |
| Phone: | E-mail: |

**Mandatory Immunizations**

1. Please fill out **either** vaccination history **or** immunization status. This information must be verified by a physician.
2. Blood tests must have lab report attached
3. Chest X-ray must have copy of report attached.

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| 1. **MMR(Measles, Mumps, Rubella)** | | | | | | |
| 1. Vaccination History   (Two doses) | Date: / / | | Date: / / | | | *Do not write here* |
| 1. Immunization status \* Blood tests must have lab report attached | **Measles** | | **Mumps** | | | **Rubella** |
| Date: / /   * Immune * Non-Immune | | Date: / /   * Immune * Non-Immune | | | Date: / /   * Immune * Non-Immune |
| 1. **Hepatitis A** | | | | | | |
| 1. Vaccination History   (Two doses) | Date: / / | | Date: / / | | | *Do not write here* |
| 1. Immunization status \* Blood tests must have lab report attached | Date: / /   * Immune * Non-Immune | | *Do not write here* | | | |
| 1. **Hepatitis B** | | | | | | |
| 1. Vaccination History   (Three doses) | Date: / / | | Date: / / | | | Date: / / |
| 1. Immunization status \* Blood tests must have lab report attached | Date: / /   * Immune * Non-Immune | | *Do not write here* | | | |
| 1. **Varicella** | | | | | | |
| 1. Vaccination History   (Two doses) | Date: / / | | Date: / / | | History of disease: | |
| 1. Immunization status \* Blood tests must have lab report attached | Date: / /   * Immune * Non-Immune | | *Do not write here* | | | |
| 1. **Tuberculosis Screening(IGRA + Chest X-ray)** | | | | | | |
| 1. IGRA test | Date: / /   * Negative * Positive | *Do not write here* | | | | |
| 1. Chest X-ray result   (taken within 3 months) | Chest X-ray test | Result | | *Do not write here* | | |
| Date: / / | * Negative * Positive | |
| 1. **T dap** | | | | | | |
| 1. Vaccination History (1 dose) | Date: / / | | *Do not write here* | | | |

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| **I hereby certify that the above information is true and correct.**  An official stamp from a doctor’s office, clinic or health department and an authorized signature must appear here or this form will not be approved  Date  Physical or Authorized Signature  Official Office Stamp Here |