

Name: _____

Date Submitted: _____

Program: _____

Date of Birth: _____

The following immunizations are **REQUIRED** by the State Health Code of New York and the hospital:

The following must be completed and signed by a health care provider.

Dear Health Care Provider:

1. If a titer is performed and shows no immunity, resident **must** be reimmunized.
2. If immunizations are needed, MMR vaccine is recommended because it provides protection against all three vaccine-preventable diseases (measles, mumps, and rubella).

Measles (rubeola):

- Rubeola titer done: Date: _____ Immune: Yes No **Enclose copy of Laboratory Report**

Rubella (german measles):

- Rubella titer done: Date: _____ Immune: Yes No **Enclose copy of Laboratory Report**

Mumps:

- Mumps titer done: Date: _____ Immune: Yes No **Enclose copy of Laboratory Report**

Varicella (chickenpox): One of the following indicators of immunity is required:

Varicella immunizations received:

Date: #1: _____

Date: #2: _____

OR

Varicella titer done:

Date: _____

Immune: Yes No **Enclose Copy of Laboratory Report**

Tetanus/Tdap: Highly recommended within past 10 years Vaccination date: _____

Hepatitis B: Highly recommended. Can be completed at SUNY Upstate Medical University

Dates: #1: _____ #2: _____ #3: _____

Antibody titer date: _____ Results: _____

Previous Tuberculin Skin Testing: (TST) (within 12 months of starting)

• Date given: _____ Product Manufacturer: _____ Lot #/Expiration Date: _____

• Date read: _____ Results: _____

• **Documentation if previous TST was positive,** Date of conversion: _____ Reaction: _____ mm x _____ mm

• **Chest x ray is required** for those who are TST positive (required within 1 year of starting)

Date: _____ Results: _____ **(Report must be enclosed)**

• **Was treatment taken for a positive TST** Yes No

Drug: _____ Date Started: _____ Date Completed: _____

ALL NEW EMPLOYEES WITH A PRIOR NEGATIVE TUBERCULIN SKIN TEST WILL ALSO HAVE A PPD PLACED BY THE HEALTH OFFICE PRIOR TO STARTING

Print name of Health Care Provider: _____ Title: _____

Signature of Health Care Provider: _____

Health Care Providers Address: _____ Telephone: (_____) _____