

**BRODY SCHOOL OF MEDICINE CLINICAL VISITOR HEALTH AND IMMUNIZATION HISTORY**

Name \_\_\_\_\_ Date of Birth (Mo/Day/Yr) \_\_\_\_\_  
First MI Last

Will you be working in  Healthcare? **Need immunizations 1, 2, 3, 4, 5, (& 6 for visitors during flu season)**  
(check all that apply)  Research Lab? **Need immunization 5, 6** (+ 4 if using human blood, body fluid or tissue  
+1, 2 & 3 if using primates)

**1. TB (required for all visitors) PPD skin test in previous 12 months**

Date of test \_\_\_/\_\_\_/\_\_\_ Result (circle one) Positive, OR Negative, OR If any previous test was **positive**, list test type, treatment dates and latest x-ray date/result \_\_\_\_\_

**2. Measles/Mumps/Rubella (MMR)**

TWO doses after 12 months of age..... \_\_\_/\_\_\_/\_\_\_ & \_\_\_/\_\_\_/\_\_\_

**OR Measles** (Rubeola) – one option must be met:

Two immunizations after 12 months ..... Dates \_\_\_/\_\_\_/\_\_\_ & \_\_\_/\_\_\_/\_\_\_ OR

Blood titer documenting immunity ..... Date of test \_\_\_/\_\_\_/\_\_\_

**AND Mumps** – one option must be met:

Two Immunizations after 12 months of age ..... Date \_\_\_/\_\_\_/\_\_\_ OR

Blood titer documenting immunity ..... Date of test \_\_\_/\_\_\_/\_\_\_

**AND Rubella** (German Measles) – one option must be met:

One Immunization after 12 months of age ..... Date \_\_\_/\_\_\_/\_\_\_ OR

Blood titer documenting immunity ..... Date of test \_\_\_/\_\_\_/\_\_\_

**3. Varicella** (Chickenpox) – one option must be met

Two Immunizations ..... Dates \_\_\_/\_\_\_/\_\_\_ and \_\_\_/\_\_\_/\_\_\_ OR

Blood titer documenting immunity ..... Date of test \_\_\_/\_\_\_/\_\_\_ OR

History of disease diagnosed by physician ..... Disease date \_\_\_/\_\_\_/\_\_\_

**4. Hepatitis B**– one option must be met

Vaccine – Series of three ..... Dates: \_\_\_/\_\_\_/\_\_\_ & \_\_\_/\_\_\_/\_\_\_ & \_\_\_/\_\_\_/\_\_\_ OR

Positive Hepatitis B Antibody Test ..... Date of test \_\_\_/\_\_\_/\_\_\_

Signed OSHA declination form

**5. Tetanus-Diphtheria and acellular Pertussis (Tdap) series AND**

Tetanus-Diphtheria booster < 10 years ago ..... \_\_\_/\_\_\_/\_\_\_

**6. Influenza Vaccine** Date of Vaccination for current flu season as required by Division of Health Sciences

Immunization ..... Date \_\_\_/\_\_\_/\_\_\_

**COMPLETE THIS SECTION ONLY IF HEALTHCARE WORKER WHO WILL PERFORM INVASIVE PROCEDURES INVOLVING SHARPS AND BODY CAVITIES (SURGERY, OBSTETRICAL OR DENTAL)**

“Applicable provisions of the North Carolina Administrative Code require that certain health care workers who know themselves to be infected with HIV or hepatitis B notify the State Health Director (please see BSOM Policy #A31 10A NCAC 41A .0207, <http://www.ecu.edu/cs-dhs/grouppractice/policies.cfm>). I certify that I have read and fully complied with the requirements of 10A NCAC 41A .0207, will comply with any practice restrictions determined by the State Health Director to be necessary, and will provide a copy of said restrictions to the ECU Office of Prospective Health, 188 Warren Building, 600 Moye Boulevard (fax: 252-744-2417) before I begin any visit to ECU Brody School of Medicine.”

I hereby certify that I meet all health and immunization requirements of the Brody School of Medicine.

Signature \_\_\_\_\_ Date \_\_\_\_\_