Immunization Form for
International Medical Professional Observer Program

Name: _____ Affiliation: _____

REQUIRED	Date of Primary Series (dd/mm/yyyy)	Date of Booster (dd/mm/yyyy)
Ⅰ: Tetanus [1)]		
Ⅱ: Pertussis		
Ⅲ: Diphtheria		

Ⅳ: **Measles**	Antibody Date:_____(dd/mm/yyyy) Method:( ) Titer [4)] :	OR	Date of Vaccination (dd/mm/yyyy) 1st dose:_____ 2nd dose:_____
Ⅴ: **Rubella**	Antibody Date:_____(dd/mm/yyyy) Method:( ) Titer [4)] :	OR	Date of Vaccination (dd/mm/yyyy) 1st dose:_____
Ⅵ: **Mumps**	Antibody Date:_____(dd/mm/yyyy) Method:( ) Titer [4)] :	OR	Date of Vaccination (dd/mm/yyyy) 1st dose:_____ 2nd dose:_____
Ⅶ: **Varicella (Chicken Pox)**	Antibody Date:_____(dd/mm/yyyy) Method:( ) Titer [4)] :	OR	Date of Vaccination (dd/mm/yyyy) 1st dose:_____ 2nd dose:_____
Ⅷ: **Hepatitis B**	Antibody*Required Date:_____(dd/mm/yyyy) Method:( ) Titer [4)] : *A positive result of more than or equal to 10 mIU/ml (EIA or CLIA) is required for Hepatitis B.*	AND	Date of Vaccination*Required (dd/mm/yyyy) 1st dose:_____ 2nd dose:_____ 3rd dose:_____
Ⅸ: **Tuberculosis**	TB skin test Date [2)]:_____(dd/mm/yyyy) □ Positive [3)] □ Negative	OR	Interferon-Gamma Release Assays (QuantiFERON or T- SPOT) Date [2)]:_____(dd/mm/yyyy) Results:_____

1) Tetanus: Booster dose should have been received within the last 10 years. If you have Tdap booster, please fill in the date of Tdap booster.

2) The medical examination of TB skin test or Interferon-Gamma Release Assays must be taken within the last year.

3) If the result is positive due to the BCG vaccine or any other causes, you must submit the report of Chest X-ray taken within the last 6 months.

4) Please check the table on the next page. The following criteria must be met to be considered to have immunity from these diseases.

Disease	Inspection Method	Criterion
Measles	EIA	≧ 4.0
	HI	≧ 1:16
	NT, CF	≧ 1:8
	PA	≧ 1:256
Rubella	EIA	≧ 4.0
	HI	≧ 1:16
Mumps	EIA	≧ 4.0
	HI	≧ 1:16
	NT, CF	≧ 1:8
Varicella	EIA	≧ 4.0
	FA	≧ 1:20
	CF	≧ 1:8
	IAHA	≧ 1:8
	Intradermal Skin Test	Positive
Hepatitis B	EIA CLIA	≧ 10mIU/ml

I certify that the immunization data given above are accurate and that this immunization status is thus up-to-date.

Physician's Name (in block capitals)

Physician's Signature

Name of Clinic or Hospital

Date

Address of Clinic or Hospital