Immunization Form for

International medical professional observer program

Name: _____ Affiliation: _____

REQUIRED	Date of Primary Series	Date of Booster
Ⅰ: **Tetanus**[1)]		
Ⅱ: **Pertussis**		
Ⅲ: **Diphtheria**		

Ⅳ: **Measles** [5)]	Antibody Date: _____ Method: ( ) Titer :	OR	Date of Vaccination 1st dose: _____ 2nd dose: _____
Ⅴ: **Rubella** [5)]	Antibody Date: _____ Method: ( ) Titer :	OR	Date of Vaccination 1st dose: _____ 2nd dose: _____
Ⅵ: **Mumps** [5)]	Antibody Date: _____ Method: ( ) Titer :	OR	Date of Vaccination 1st dose: _____ 2nd dose: _____
Ⅶ: **Varicella** [5)] **(Chicken Pox)**	Antibody Date: _____ Method: ( ) Titer :	OR	Date of Vaccination 1st dose: _____ 2nd dose: _____
Ⅷ: **Hepatitis B**	Titer : Date : _____ □ Positive [2)] □ Negative	OR	Date of Vaccination 1st dose: _____ 2nd dose: _____ 3rd dose: _____
Ⅸ: **Tuberculosis**[3)]	TB skin test [4)] Date : _____ □ Positive □ Negative	OR	Interferon-Gamma Release Assays [4)] (QuantiFERON or T- SPOT) Date: _____ 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)] *A positive result of more than or equal to 10 mIU/ml is required for hepatitis B. If the result is less than 10 mIU/ml, you must submit the date of the vaccination.*

[3)] *If the result is positive because of BCG vaccine or any other causes, you must submit an official report of a chest x-ray taken within the last 6 months.*

[4)] *The medical examination of TB skin test or interferon-gamma release assays must be taken within the last year.*

[5)] *Please check the table below. 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

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

CONSULTANT MEDICAL GASTROENTEROLOGIST

Name of clinic

Date

Address

Revised June. 2017