***Immunization Form for***

***International Visiting Physicians, Nurses and Other Medical Professionals Program***

Name: Affiliation:

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

*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.*

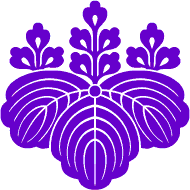
|  |  |  |  |
| --- | --- | --- | --- |
| Ⅳ: **Measles** 5) | Antibody  Date:  Method: ( )  Titer : | OR | Date of Vaccination  1st dose:  2nd dose: |
| Ⅴ: **Rubella** 5) | Antibody  Date:  Method: ( )  Titer : | OR | Date of Vaccination  1st dose:  2nd dose: |
| Ⅵ: **Mumps** 5) | Antibody  Date:  Method: ( )  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 Assays４）  (QuantiFERON or T- SPOT)  Date:  Results: |

*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.*

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*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  HI  NT, CF  PA | ≧ 4.0  ≧1:16  ≧ 1:8  ≧1:256 |
| Rubella | EIA  HI | ≧ 4.0  ≧1:16 |
| Mumps | EIA  HI  NT, CF | ≧ 4.0  ≧1:16  ≧ 1:8 |
| Varicella | EIA  FA  CF  IAHA  Intradermal Skin Test | ≧ 4.0  ≧1:20  ≧ 1:8  ≧ 1:8  Positive |

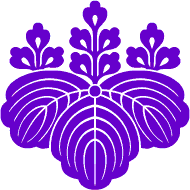
I certify that the immunization data given above are accurate and that this immunization status is thus up-to-date.

*Physician’s name (in block capitals) Physician’s signature*

*Name of clinic Date*

*Address*

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