***Immunization Form for***

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

Name: Affiliation:

|  |  |  |
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| **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.*

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| --- | --- | --- | --- |
| Ⅳ: **Measles** 5) | AntibodyDate: Method: ( )Titer :  | OR | Date of Vaccination 1st dose:  2nd dose:  |
| Ⅴ: **Rubella** 5) | AntibodyDate: Method: ( )Titer :  | OR | Date of Vaccination 1st dose: 2nd dose:  |
| Ⅵ: **Mumps** 5) | AntibodyDate: Method: ( )Titer :  | OR | Date of Vaccination 1st dose:  2nd dose:  |
| Ⅶ: **Varicella** 5)**(Chicken Pox)** | AntibodyDate: 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.*

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| Disease | Inspection Method | Criterion |
| Measles  | EIAHINT, CFPA | ≧ 4.0≧1:16≧ 1:8≧1:256 |
| Rubella | EIAHI | ≧ 4.0≧1:16 |
| Mumps  | EIAHINT, CF | ≧ 4.0≧1:16≧ 1:8 |
| Varicella | EIAFACFIAHAIntradermal Skin Test | ≧ 4.0≧1:20≧ 1:8≧ 1:8Positive |

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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