***Immunization Form for***

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

Name : Affiliation :

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

*\* 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** | Titre  Date:  □ Positive  □ Negative | OR | Date of Vaccine  Dose 1:  Dose 2: |
| Ⅴ: **Rubella** | Titre  Date:  □ Positive  □ Negative | OR | Date of Vaccine  Dose 1:  Dose 2: |
| Ⅵ: **Mumps** | Titre  Date:  □ Positive  □ Negative | OR | Date of Vaccine  Dose 1:  Dose 2: |
| Ⅶ: **Varicella**  **(Chicken Pox)** | Titre  Date:  □ Positive  □ Negative | OR | Date of Vaccine  Dose 1:  Dose 2: |
| Ⅷ: **Hepatitis B** | Titre  Date:  □ Positive\*\*  □ Negative | OR | Date of Vaccine  Dose 1:  Dose 2:  Dose 3: |
| Ⅸ: **Tuberculosis\*\*\*** | TB skin test\*\*\*\*  Date:  □ Positive  □ Negative | OR | Interferon-Gamma Release Assays\*\*\*\*  (Quantiferon or T- SPOT)  Date:  Results: |

*\*\* 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.*

*\*\*\* 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.*

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

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: