Immunization Form for International Medical Professional Observer Program

Name: ______________________________________ Affiliation: ____

Immunity testing methods and positive criteria for infectious diseases

Disease	Titer Method	Positive Criteria
Measles	EIA-IgG (recommended)	≧ 16.0
Rubella	EIA-IgG (recommended)	≧ 8.0
Mumps	EIA-IgG (recommended)	≧ 4.0
Varicella	EIA-IgG (recommended)	≧ 4.0
Hepatitis B	anti-HBs antibody	≧ 10mIU/ml

cf. : CDC. Immunization of Health-care Personnel. *Morbid Mortal Wkly Rep.* 2011;60:RR-7.
※Vaccine Guidelines for Healthcare Professionals, Japan Society for Infection Prevention and Control, 2nd ed.

Please refer to the criteria in the table above to indicate immune or vaccination status for each disease.

I: **Measles**	Antibody: □ positive, □ negative Date (year):_______________	OR	Date of Vaccination 1st dose (year):________________________ 2nd dose (year):________________________
II: **Rubella**	Antibody: □ positive, □ negative Date (year):_______________	OR	Date of Vaccination 1st dose (year):________________________ 2nd dose(year):________________________
III: **Mumps**	Antibody: □ positive, □ negative Date (year):_______________	OR	Date of Vaccination 1st dose (year):________________________ 2nd dose (year):________________________
IV: **Varicella** **(Chicken Pox)**	Antibody: □ positive, □ negative Date (year):_______________	OR	Date of Vaccination 1st dose (year):________________________ 2nd dose (year):________________________
V: **Hepatitis B**	Antibody: □ positive, □ negative Date (year):_______________		
VI: **Tuberculosis*** *Applicants from low-tuberculosis incidence countries are exempt from answering this section	TB skin test Date [1]:__________________ □ Positive [2] □ Negative	OR	Interferon-Gamma Release Assays (QuantiFERON or T- SPOT) Date [1]:______________________________ □ Positive [2] □ Negative

1) *TB skin test or Interferon-Gamma Release Assays must be from within the last 12 months.*
2) *If the result is positive, you must submit a report with a chest X-ray taken within the last 6 months.*

To the best of my knowledge, I certify that the immunization data given above are accurate and that this immunization status is up to date.

____

Physician's Name (in block capitals)

____

Physician's Signature

____

Name of Clinic or Hospital

____

Date

____

Address of Clinic or Hospital

University of Tsukuba Hospital
Revised February 2025