



## Checklist of Health Care Requirements for Medical Trainees

All prospective medical trainees (interns) irrespective of duration of rotation at King Abdulaziz Medical City – NGHHA Riyadh **must have this form completed by their sponsoring institution or university, signed and stamped by a Licensed Physician.**

Name of Applicant: \_\_\_\_\_

Sponsoring Institution: \_\_\_\_\_

Proposed Training Area: \_\_\_\_\_

Start Date of Rotation: \_\_\_\_\_ End Date of Rotation: \_\_\_\_\_

	Result	Remarks	
Tuberculin skin test (TST) Result in millimeters		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Chest radiograph (if TST is more than 10mm)		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Hepatitis B antibody titers=or>10mIU/ml		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Hepatitis B surface antigen		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Anti-HCV antibody		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
HIV Antibody		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Varicella zoster antibody		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Varicella zoster vaccine if not antibody Positive(two doses)			
Rubella antibody		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Measles antibody		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
Proof of Hepatitis B vaccine (series of commencement if non immune)			
Proof of two doses of MMR vaccine if non immune to Rubella or Measles			

Sponsoring Institution: \_\_\_\_\_

Name of Attending Physician/Doctor: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**OFFICIAL  
STAMP**