

Part 2: Required for all Health Professions Students**4. TUBERCULOSIS (TB) – ± Required for Health Professions Students – All other students to complete TB Risk Assessment Form (in packet)**

STEP 1: TB Blood Test/IGRA		OR	TB Skin Test (PPD)	STEP 2: DO NOT COMPLETE UNLESS POSITIVE TB SKIN TEST OR TB BLOOD TEST		
<input checked="" type="checkbox"/> QuantiFERON <input checked="" type="checkbox"/> T-Spot Date: <u>01-01-2023</u> MM DD YYYY RESULT: <input checked="" type="checkbox"/> NEG <input checked="" type="checkbox"/> POS* Required: <input checked="" type="checkbox"/> Attach lab results.		Date planted: <u>06-15-2023</u> MM DD YYYY Date read: <u>06-30-2023</u> MM DD YYYY Interpretation: <input checked="" type="checkbox"/> NEG <input checked="" type="checkbox"/> POS* mm of induration: <u>9</u>		CHEST XRAY Required if past or current positive TB skin or blood test. Not required if completed medication treatment for TB. Chest X-ray Date: <u>01-01-2024</u> MM DD YYYY <input checked="" type="checkbox"/> Normal <input checked="" type="checkbox"/> Abnormal		TB TREATMENT <input checked="" type="checkbox"/> Latent TB Infection <input checked="" type="checkbox"/> Active TB Infection Date(s): <u>06-30-2023</u> MM DD YYYY List Medication(s): <u>None</u>

5. COVID-19 VACCINATION – ± Required for Health Professions Students – Strongly encouraged for all other students.
 • Please submit documentation of prior vaccine doses **AND at least one (1) dose of 2023-2024 updated formulation.**

PRIMARY DOSE #1	PRIMARY DOSE #2 (skip if J&J vaccine)	COVID-19 updated 2023-2024 dose
Date: <u>03-15-2021</u> MM DD YYYY <input checked="" type="checkbox"/> Moderna <input checked="" type="checkbox"/> Pfizer <input checked="" type="checkbox"/> Johnson & Johnson/Janssen <input checked="" type="checkbox"/> Novavax <input checked="" type="checkbox"/> Other WHO approved Name: <u>Bob</u>	Date: <u>04-15-2021</u> MM DD YYYY <input checked="" type="checkbox"/> Moderna <input checked="" type="checkbox"/> Pfizer <input checked="" type="checkbox"/> Novavax <input checked="" type="checkbox"/> Other WHO approved Name: <u>Sam</u>	Date: <u>10-13-2023</u> MM DD YYYY <input checked="" type="checkbox"/> Moderna <input checked="" type="checkbox"/> Pfizer <input checked="" type="checkbox"/> Novavax Name: <u>Test</u>

6. Hepatitis B Immunity – ± Required for Health Professions Students – Not required for all other students.
 Documentation of a COMPLETE series of Hepatitis B vaccination AND quantitative antibody titer.

Hepatitis B Vaccine (enter name)	Date of Dose #1:	Date of Dose #2:	Date of Dose #3 (if applicable):	Hep B Surface Antibody Titer (QUANTITATIVE)
	<u>01-01-2022</u> MM DD YYYY	<u>03-01-2022</u> MM DD YYYY	<u>05-01-2022</u> MM DD YYYY	<u>06-01-2023</u> MM DD YYYY Result: <u>12</u> IU / sc <input checked="" type="checkbox"/> Immune <input checked="" type="checkbox"/> Not Immune

7. TETANUS-DIPHTHERIA-PERTUSSIS (Tdap) – ± Required for Health Professions Students – Not required for all other students.

Only Tdap is accepted within the past 10 years	Date of most recent Tdap dose:
	<u>02-10-2024</u> MM DD YYYY

8. INFLUENZA VACCINATION: ± Required for Health Professions Students, documentation to be submitted during flu season. Recommended but not required for all other students.

Influenza (Flu) Vaccination	Date of Influenza Vaccination:
	<u>10-13-2023</u> MM DD YYYY Must be between September and March of CURRENT academic year

Part 3: Recommended vaccines based on personal history – (please record if applicable)**OTHER VACCINES - NOT required**

Hepatitis A Vaccine	Date of Dose #1: <u>01-01-2006</u> MM DD YYYY	Date of Dose #2: <u>03-01-2006</u> MM DD YYYY		
HPV Vaccine	<input checked="" type="checkbox"/> HPV 4 <input checked="" type="checkbox"/> HPV 9	Date of Dose #1: <u>01-01-2004</u> MM DD YYYY	Date of Dose #2: <u>03-01-2004</u> MM DD YYYY	Date of Dose #3: <u>05-01-2004</u> MM DD YYYY
Meningococcal Serogroup B Vaccine	<input checked="" type="checkbox"/> Bexsero, 2 doses <input checked="" type="checkbox"/> Trumenba, 3 doses	Date of Dose #1: <u>01-01-2004</u> MM DD YYYY	Date of Dose #2: <u>03-01-2004</u> MM DD YYYY	Date of Dose #3 (if Trumenba): <u>05-01-2004</u> MM DD YYYY
Yellow Fever	<input checked="" type="checkbox"/> Yellow Fever <input checked="" type="checkbox"/> Stamaril	Date of Dose: <u>06-01-2010</u> MM DD YYYY		
Typhoid	Date of Dose: <u>06-01-2010</u> MM DD YYYY			

Part 4: Medical Provider Certification of the Above Information

Medical Provider Name <u>Dr Rubenstein</u>	Medical Provider Signature	Date <u>02-20-2024</u> Month Day Year
Address (Include city and state) <u>5 Peguot Pl. Westbrook, CT</u>		Telephone <u>203 555 1212</u>
State or Country of Licensure / License # <u>CT 1234567</u>		Fax <u>203 555 1213</u>

Form must be stamped or Signed by Medical Provider

Stamp

Signature

 <p>Dr. OMKAR PATIL Resident Dept. Of General Surgery MIMER Medical College & BSRH Talegaon Dabhade, Pune-410 07 MBBS Reg.No. 2016/08/2</p>	
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