Occupational & Environmental Medicine
Doctor's Office Building
720 Harrison Avenue
Boston, MA 02118-2393
Phone 617-638-8400
Fax 617-638-8406
occmed@BMC.org

Last Name, First Name,M.I. _____

Date of Birth (MM/DD/YYYY) _____ Department _____

Social Security# _____ Projected Start Date _____

Email address _____

☐ I was a BU student ☐ I was a BMC resident / fellow

BOSTON MEDICAL CENTER RESIDENT & FELLOW IMMUNIZATION FORM

Completed record of immunizations and screening procedures must be up to date and input to New Innovations by May 16, 2015 for clearance to start your training program. If vaccinations are in process, provisional clearance will be granted.
Self-attestation is not accepted. School, employment, primary care provider, travel, or military immunization records; original lab or chest x-ray results can be submitted in lieu of this form.

Immunization	Vaccine Date	or	Date of titer demonstrating immunity
MMR no. 1	____ / ____ / ____		
MMR no. 2	____ / ____ / ____		
or			
Measles 1 (if no MMR)	____ / ____ / ____	or	____ / ____ / ____
Measles 2 (if no MMR)	____ / ____ / ____		
Mumps 1 (if no MMR)	____ / ____ / ____	or	____ / ____ / ____
Mumps 2 (if no MMR)	____ / ____ / ____		
Rubella (if no MMR)	____ / ____ / ____	or	____ / ____ / ____
Tetanus, Diphtheria, Pertussis (Tdap)	____ / ____ / ____		
Hepatitis B no. 1	____ / ____ / ____	titer required:	HBsAB ____ / ____ / ____
Hepatitis B no. 2	____ / ____ / ____		or HBcAB____ / ____ / ____
Hepatitis B no. 3	____ / ____ / ____		or HBsAG____ / ____ / ____
Hepatitis B #4, #5, #6	____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____		
Varicella 1	____ / ____ / ____	or	____ / ____ / ____
Varicella 2	____ / ____ / ____		
Varicella (Chicken Pox)	Date of provider verified disease ____ / ____ / ____		

Two Negative Tuberculin Skin Test (TST)

(If TST+, complete TST+ Form instead)

Most recent TST (must be within 3 months of start; use 5 TU Mantoux test (intermediate PPD) only; result of other tests, such as Tine, Monovac; IGRA (unless+) not accepted.)	Second most recent TST (must be more than 2 weeks but within 12 months of most recent TST)
Plant Date ____ / ____ / ____	**Plant Date** ____ / ____ / ____
Read Date ____ / ____ / ____	**Read Date** ____ / ____ / ____
_____mm	_____mm

_____ MD/NP/PA _____ _____
Print Name; Signature State, License Number Date

OEM Review: MD/NP/PA/RN Signature_____ Date_____

☐ Clearance Granted ☐ Provisional Clearance Until: ___/___/___ ☐ Other action: _____

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Positive Tuberculosis Skin Test Documentation

This form is to be completed by your treating provider. School, employment, primary care provider, TB clinic, travel, or military immunization records; original lab or chest x-ray results can be submitted in lieu of this form. *Self-attestation is not acceptable.* **Information must be uploaded to your New Innovations webpage by May 16th, 2015**.

Positive Tuberculin Skin Test (TST) Documentation

Date planted: ____ / ____ / ____ Date Read: ____ / ____ / ____ Results in _____mm

+ IGRA date: ____ / ____ / ____ If negative, and no documentation of + TST, please submit the results of 2 TB skin tests as noted on the immunization page.

Chest x-ray result (done after + TST or + IGRA reading):

Date: ____ / ____ / ____ ☐ Normal ☐ Abnormal:_____
(Describe)

Clinical Evaluation Date: ___ / ____ / ____

☐ No symptoms (no fever, night sweats, unexplained weight loss, unexplained fatigue, persistent cough, coughing up blood)

☐ Abnormal:_____
(Describe)

Treatment:

☐ Medication counseling completed – discussed pros/cons, options/recommendations: Date_____

☐ Has documented treatment history: Date_____ Treatment completed: ☐ Yes ☐ No

Clinician Signature:

_____ MD/NP/PA _____ _____
Print Name; Signature State, License Number Date

OEM Review: MD/NP/PA/RN Signature_____ Date_____

☐ Clearance Granted ☐ Provisional Clearance Until: ___/___/___ ☐ Other action: _____

Form Version 3/1/15 G:OEM forms/Preplacement/Immunization & Screening letters