

BRODY SCHOOL OF MEDICINE LONG TERM VISITOR HEALTH AND IMMUNIZATION HISTORY

(For visits spanning more than 14 consecutive calendar days)

Name _____ Date of Birth (Mo/Day/Yr) _____
First MI Last

Will you be working in Healthcare? **Need immunizations 1, 2, 3, 4**
(check all that apply) Research Lab? **Need immunization 5** (+ 4 if using human blood, body fluid or tissue
+ 6 if using wild animals, +1, 2 & 3 if using primates)

1. TB PPD skin test in previous 12 months

Date of test ___/___/___ Result (circle one) Positive, OR Negative, OR If any previous test was **positive**, list test type, treatment dates and latest x-ray date/result _____

2. Measles/Mumps/Rubella (MMR)

TWO doses after 12 months of age ___/___/___ & ___/___/___

OR Measles (Rubeola) – one option must be met:

Two immunizations after 12 months if born in or after 1956..... Dates ___/___/___ & ___/___/___ OR
or one immunization if born before 1957..... Date ___/___/___ OR

Blood titer documenting immunity Date of test ___/___/___ OR

AND Mumps – one option must be met:

Immunization after 12 months of age Date ___/___/___ OR

Blood titer documenting immunity Date of test ___/___/___ OR

History of disease diagnosed by physician and born before 1/1/1957 Disease date ___/___/___

AND Rubella (German Measles) – one option must be met:

Immunization after 12 months of age Date ___/___/___ OR

Blood titer documenting immunity Date of test ___/___/___

3. Varicella (Chickenpox or Shingles) – one option must be met

Immunizations Dates ___/___/___ and ___/___/___ OR

Blood titer documenting immunity Date of test ___/___/___ OR

History of disease Disease date ___/___/___
(If born before 1980 only)

4. Hepatitis B– one option must be met

Vaccine – Series of three Dates: ___/___/___ & ___/___/___ & ___/___/___ OR

Positive Hepatitis B Antibody Test..... Date of test ___/___/___

Signed OSHA declination form

5. Tetanus-Pertussis-Diphtheria series as a child AND

Tetanus-Diphtheria booster < 10 years ago ___/___/___

6. Rabies – Lab/Research visitors exposed to wild animals or carcasses

Vaccine – Series of three ___/___/___ & ___/___/___ & ___/___/___ OR

Blood titer documenting immunity Date ___/___/___

COMPLETE THIS SECTION ONLY IF HEALTHCARE WORKER WHO WILL PERFORM INVASIVE PROCEDURES INVOLVING SHARPS AND BODY CAVITIES (SURGERY, OBSTETRICAL OR DENTAL)

“Applicable provisions of the North Carolina Administrative Code require that certain health care workers who know themselves to be infected with HIV or hepatitis B notify the State Health Director (please see BSOM Policy #A31 10A NCAC 41A .0207, <http://www.ecu.edu/cs-dhs/grouppractice/policies.cfm>). I certify that I have read and fully complied with the requirements of 10A NCAC 41A .0207, will comply with any practice restrictions determined by the State Health Director to be necessary, and will provide a copy of said restrictions to the ECU Office of Prospective Health, 188 Warren Building, 600 Moye Boulevard (fax: 252-744-2417) before I begin any visit to ECU Brody School of Medicine.”

I hereby certify that I meet all health and immunization requirements of the Brody School of Medicine.

Signature _____ Date _____