TK Orthopedic Surgery 

 *Immunization Certificate*

To help promote the health of our international visitors and to minimize the potential for transmission of communicable diseases from/to hospital staffs and patients, health care workers are required to have proof of vaccination or evidence of immunity against the following vaccine-preventable diseases and tuberculosis information according to the description.

Section A:

**- MMR (Measles, Mumps and Rubella)**: 2 vaccinations are required unless there is evidence of immunity.

**-** **Varicella (Chickenpox)**: 2 vaccinations are required unless there is evidence of immunity and/or a positive history of the disease with evidence of immunity.

**-** **Tdap (Tetanus-Diphtheria-Pertussis)**: A booster vaccination in the last 10 years.

**- HBV (Hepatitis B)**: 3 vaccinations are required and a blood test result (serologic proof) showing your immunity against HBV.

Section B: Tbc Information

**- Tbc (Tuberculosis)**: If Tuberculosis skin test (TST) or IGRA (interferon-gamma release assay) is positive, a chest x-ray that was taken within 1 year is required.

Please let us know if you have any additional vaccinations you have received such as Influenza, Polio, Hepatitis A etc. You do not have to provide certification for these vaccinations.

**Basic Instructions:**

* All Immunization records are required to be submitted in, or translated into English and in MM/DD/YYYY format.
* Must include the applicant’s name and contact number.
* Have forms completed by a doctor’s office, clinic or health department. An “official stamp” and an official signature plus the address and phone number from one of these entities must be included for documents to be complete and accepted.

**Applicant's Information:**

**Full name: Date of Birth:**

**Nationality:**

**Address:**

**Email ID: Contact No:**

**Section A: Mandatory Immunization**

MMR (Measles, Mumps and Rubella)

MMR # 1 \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ MMR #2 \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_

 OR

Measles #1 \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ Measles #2 \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ OR

Mumps #1 \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ Mumps #2 \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ OR

Rubella #1 \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ Rubella #2 \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ OR

Serology \_\_\_\_\_\_\_\_\_

Serology \_\_\_\_\_\_\_\_\_

Serology \_\_\_\_\_\_\_\_\_

Varicella (Chickenpox)

Varicella # 1 \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ Varicella #2 \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_

OR

Serology \_\_\_\_\_\_\_\_\_

 OR

Past History: Year of Disease \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

Tdap (Tetanus-Diphtheria-Pertussis)

A Booster Vaccination within the past 10 years

Date of Administration: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_

Hepatitis B

HBV # 1 \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ HBV #2 \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_

Please tick the box that fits your test result.

HBsAb □ Positive □ Negative

HBsAg □ Positive □ Negative

HBV #3 \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_

**Section B: Tbc Information**

Tuberculosis Screening (Test must be performed within the last year.)

**Tuberculin Skin Test**  Please tick the box that fits your test result.

(Must include copy of test result) □ Positive: Induration (mm) \_\_\_\_ in diameter □ Negative

 Date of Test: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

**Interferon-Gamma Release Assay** □ Positive □ Negative

Date of Test: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

**If positive, a chest X-ray is required within 1 year of start date.**

Date of Test: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ Results:

**Additional Immunization:**

|  |  |  |  |
| --- | --- | --- | --- |
| Immunizations |  Date  | OR | Serology Results |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |  |
| **Physician’s Signature** |  |  | **Date (DD/MM/YY)** |