CUMC VISITING STUDENT VACCINATION FORM

Failure to complete the following form in its entirety will result in a denial of your application. Do NOT attach additional immunization records to this form, unless you are required to attach Chest X-Ray Reports.

1. The Vaccination Form is to be completed and signed by a health care official. All sections are required.

2. Equivocal, inconclusive, or low-positive titers are considered to be negative.

3. This form is REQUIRED for students to enroll in an elective. Students WILL NOT be approved without showing proof of the following on this form:
   a. **Positive titers for Measles, Mumps, and Rubella.** If any titers are negative, an MMR booster shot must be indicated.
   b. **Hepatitis B series** and a positive post-immunization titer for Hepatitis B.
      i. If the post-immunization titer is negative, the Hep B Surface Antigen test must be performed. If both the Antibody and Antigen tests are negative, a fourth Hep B shot must be indicated.
   c. A **negative Hepatitis C** antibody **within one year** of the desired rotation month.
      i. Example: If applying for an October 2014 rotation, a negative Hepatitis C antibody must be recorded **on or after** October 1, 2013.
   d. A positive titer for **Varicella** if there is a history of Varicella disease or proof of receipt of 2 doses of Varicella vaccine at least 30 days apart.
   e. A **Td booster** within 10 years.
   f. A **PPD or Quantiferon Gold** test **within one year** of the start date of the desired elective. If the PPD is greater than 10mm or the Quantiferon Gold test is positive, the clinician must answer the health questions and a negative chest X-ray report must be attached.
   g. Results from a **respirator fit test** are required for placement, including type, size, and make of model. **International students may leave this section blank.**
   h. Clinician-verified physical exam date **within one year** of the desired rotation month.
   i. **Influenza Vaccinations** are required. Clinicians filling out the form should note the date the immunization was placed. Students without an influenza vaccination will be required to wear a mask in all patient areas.
   j. **Signature of clinician.**

4. Chest X-ray reports must be attached if required.

5. Students with acceptable insurance may access local in-network providers for their ongoing healthcare needs; if an occupational exposure is sustained, visiting students must go to the emergency room immediately.

By submitting this form, you affirm that all the information is correct, and Sections 3, 6, and 8 have been completed within one year of the rotation date. You also affirm that failure to complete this form in its entirety, and failure to meet the deadlines for Sections 3, 6, and 8 will result in an automatic denial of your application. You may upload this form without this information being complete, but please be aware that we will not place you if you do not have it updated by the 60 day deadline prior to the desired rotation month.
### CUMC VISITING STUDENT VACCINATION FORM

**Student Name:** ________________________________  **Date:** ________________________________

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**SECTION 1: Measles, Mumps, Rubella Immunity**

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Date (format: mm/dd/yyyy)</th>
<th>Pos</th>
<th>Neg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles Titer (lgG)</td>
<td>[date]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Mumps Titer (lgG)</td>
<td>[date]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Rubella Titer (lgG)</td>
<td>[date]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>MMR #1</td>
<td>[date]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR #2</td>
<td>[date]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR #3</td>
<td>[date]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(A third MMR shot is required only if any MMR titers not positive)*

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**SECTION 2: Hepatitis B Immunity**

<table>
<thead>
<tr>
<th>Hepatitis B Titer</th>
<th>Date (format: mm/dd/yyyy)</th>
<th>Pos</th>
<th>Neg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B #1</td>
<td>[date]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hepatitis B #2</td>
<td>[date]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hepatitis B #3</td>
<td>[date]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

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**SECTION 3: Hepatitis C Antibody**

- [ ] Pos [ ] Neg

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**SECTION 4: Varicella Immunity**

- [ ] Yes [ ] No

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**SECTION 5: Tetanus Immunity**

- [ ] Pos [ ] Neg

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**SECTION 6: Tuberculosis Testing**

- [ ] Pos [ ] Neg

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**SECTION 7: Respirator Fit Testing**

<table>
<thead>
<tr>
<th>Size</th>
<th>Make</th>
</tr>
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<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
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</tbody>
</table>

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**SECTION 8: Physical Exam**

- [ ] Pos [ ] Neg

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**SECTION 9: Influenza Vaccination**

- [ ] Yes [ ] No

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**Clinician Name (printed):** ________________________________

**Signature:** ________________________________  **Date:** ________________________________

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**I certify that this student is in good health without contraindications to clinical care of patients.**

- [ ] Yes [ ] No