COMMUNITY MEDICAL CENTER
From day one.

Immunization Verification Form

Authorized Facility Representative Use Only

Name_____ **Facility**_____
Please Print

Please insert dates and check boxes below as applicable. **Current**

MMR (measles, mumps, rubella) **Yes☐** **No☐**

MMR Record 1_____/_____/_____ Record 2_____/_____/_____

Use below **only** if measles, mumps and rubella vaccinations were administered separately.

Measles____/____/_____, mumps_ /____/_____, rubella____/____/_____

Measles____/____/_____, mumps_ /____/_____, rubella____/____/_____

OR

Positive titer dates for Measles____/____/_____, mumps_ /____/_____, and rubella____/____/_____

Varicella (chickenpox) **Yes☐** **No☐**

Vaccination dates_____/_____/_____AND_____/_____/_____(two recommended by the CDC)

OR titer date____/____/_____**OR** recollection of having the disease _____
(Year or age had disease)

Hepatitis B **Yes☐**

No☐ Record 1_____/_____/_____Record 2_____//___Record3___/_____/

_____**and** positive Titer date _ /_____/_____ **OR** Can be declined but student must sign a declination.

Date signed_____/_____/_____

Tetanus w/ Pertussis (Tdap) *Note this must be Tdap not TD or DPT* _ **Yes☐** **No☐**

Date shot received____/____/_____

Record of current flu shot **Fill in dates vaccinations were administered for every year the student is in clinical rotations.**

First Year	
Second Year	
Third Year	
Fourth Year	

TB (PPD-tuberculosis) Record of two negative TB tests in the last twelve months within 7-21 days of each other or a negative Quantifer on TB test is required. After initial 2-step has been completed and approved an annual questionnaire can be completed and sent to the site for approval with a copy of the original 2-step results.

Date of First Negative TB Test Results	Date of Second Negative TB Test Results	Returning Annual TB Questionnaire Signed Date	ORGNAIZATION Approval Date for Questionnaire	Date of Negative Quantiferon
If results any TB test results are positive a chest x-ray will be required. Date of negative chest x-ray approval._____/_____/_____				

Proof of this information is to be kept and maintained by the facility unless other arrangements have been made with Community Medical Center. Actual immunization records are not to be submitted to Community Medical Center unless prior arrangements have been made. By signing below, I am verifying that proof of this information is on file with the facility or the records have been submitted to Community Medical Center. If requested, we will provide these documents to Community Medical Center within one business day of the request for random audits. The facility will be responsible to keep these records up to date and inform the student in advance when an immunization expiration date is approaching.

_____ _____
Representative Signature Date

_____ _____
Print Name Title

_____ _____
Phone Number Email address

A copy of this form will be provided to Community Medical Center prior to the start of the nurse's residency experience.

Updated 4/20/16