YALE-NEW HAVEN HOSPITAL
MANDATORY MEDICAL CLEARANCE FORM

Name: _____ **Current Hospital:** _____

Signature: _____ **Date:** _____

1 Date of most recent PPD _____ /_____ /_____ (within the last year, if negative)

If **PPD** positive, date and result of chest x-ray subsequent to positive PPD:

DATE _____ /_____ /_____ **RESULT** _____

2. Have you ever had the chickenpox? **YES** _____ **NO** _____

If you have had a varicella titer drawn, what was the result?

POSITIVE _____ **NEGATIVE** _____

3. Were you born after January 1, 1957? **YES** _____ **NO** _____

If yes, when was you most recent measles vaccine? **DATE** _____ /_____ /_____

If you had a measles titer drawn, what was the result?

POSITIVE _____ **NEGATIVE** _____

4. Have you been vaccinated against rubella? **YES**_____ **NO**_____

If yes, when was your most recent rubella vaccine? **DATE** _____ /_____ /_____

If you had a rubella titer drawn, what was the result?

POSITIVE _____ **NEGATIVE** _____

5. Have you received the **Hepatitis B** vaccine series? **YES** _____ **NO** _____

If yes, what was the date of the vaccine? **DATE** _____ /_____ /_____

If you hade a hepatitis titer drawn, what was the result?

POSITIVE _____ **NEGATIVE** _____

If you do not have a positive Hepatitis B surface antibody titer, have not received the Hepatitis B vaccine, and do not intend to do so, please sign the following declination:

I _____ *decline to receive the Hepatitis B vaccine.*
(print name)

Signed: _____

6. Have you been fit-tested for a respirator: **YES** _____ **NO** _____

If yes, what type of respirator: _____