

**YALE NEW HAVEN HEALTH  
IMMUNIZATION TESTING RECORD**

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 DEPARTMENT: \_\_\_\_\_ DATE: \_\_\_\_\_

<b>DOCUMENTATION OF IMMUNIZATIONS/TITERS</b>		
	<b>DATES of vaccine or titer</b>	<b>TITER RESULT</b>
MEASLES VACCINE (dates for both doses) <b>or</b> MEASLES TITER (if no vaccine)		N/A
RUBELLA VACCINE (dates for both doses) <b>or</b> RUBELLA TITER (if no vaccine)		N/A
MUMPS VACCINE (dates for both doses) <b>or</b> MUMPS TITER (if no vaccine)		N/A
VARICELLA VACCINE received (2 doses of Varivax) <b>or</b> History of physician-diagnosed illness (chicken pox, herpes-zoster) VARICELLA TITER (if neither of the above)		N/A
TETANUS-DIPHTHERIA-PERTUSSUS VACCINE received (must be since 2005)		N/A
TB SKIN TEST (negative within past 12 months) <b>or</b> IGRA (negative within past 12 months)		N/A
INFLUENZA VACCINE (annual)		N/A

**PPD or IGRA Positive**

If **PPD/IGRA** positive, did you have a chest x-ray: **YES** \_\_\_\_\_ (please include results) **NO** \_\_\_\_\_

If **PPD/IGRA** positive, did you receive prophylactic anti-tuberculosis therapy? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**HEPATITIS B**

Have you received the **Hepatitis B** Vaccine series? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

If no, you must complete the Hepatitis B declination and waiver form.

If yes, what was the result of your **Hepatitis B** surface antibody test following the vaccine series?

**POSITIVE** \_\_\_\_\_

**NEGATIVE** \_\_\_\_\_

## HEPATITIS B VACCINE DECLINATION

**(Please sign if you are declining HepB vaccination):**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

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(Signature)

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Please print Full Name

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(Date)

**YALE NEW HAVEN HEALTH  
MEDICAL STAFF REQUIREMENTS  
IMMUNIZATIONS AND TB SURVEILLANCE**

Based upon current standards of OSHA/AHA/CDC/Joint Commission and YNHHS policy, applicants to the Medical Staff and Clinical Fellows are required to submit their immunization/test records to Medical Staff Administration along with the application for appointment. For your convenience, a standardized reporting form is enclosed. The following documentation is required:

- ◆ **MEASLES** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable:  
A statement of date of positive antibody titer  
Or  
Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)
  
- ◆ **RUBELLA** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable:  
A statement of date of positive antibody titer  
Or  
Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)
  
- ◆ **MUMPS** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable:  
A statement of date of positive antibody titer  
Or  
Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)
  
- ◆ **HEPATITIS B**  
A statement of date of positive hepatitis b surface antibody titer  
Or  
Date of completion of Immunization series  
Or  
Signed attached declination and waiver
  
- ◆ **VARICELLA-ZOSTER VIRUS**  
A statement of history of physician-diagnosed illness (chicken pox, shingles, or herpes-zoster)  
Or  
Dates of Immunization with Varivax (2 doses)  
Or  
Result of antibody titer.
  
- ◆ **TETANUS-DIPHTHERIA-PERTUSSIS**  
Date of immunization with Tdap since 2005
  
- ◆ **TB SKIN TEST**  
A negative 2-step PPD within the most recent 12 months  
Or  
For those with two years of serial PPD testing, a single baseline negative PPD within most recent 12 months  
Or  
A negative Interferon Gamma Release Assay (IGRA) result for TB within past 12 months

Or

For those with a positive PPD or positive IGRA, date of evaluation for Latent TB Infection (LTBI) and a chest radiograph report subsequent to positive PPD or positive IGRA.

*Members of the Medical Staff with negative PPD or negative IGRA result will be required to document annual PPD or IGRA testing during the bi-annual re-credentialing process.*

◆ **INFLUENZA**

Vaccination required annually: evidenced by documentation from OHS, attestation by practitioner of vaccine receipt, or statement of declination for medical or religious reason.

***Special Considerations for Lawrence and Memorial and Westerly Hospitals:***

Medical Staff of Lawrence and Memorial and Westerly Hospitals **not** employed by NEMG are strongly recommended to receive influenza vaccine, but may decline the vaccine.

**ADDITIONAL REQUIREMENTS**

Medical Staff who care for patients in negative pressure isolation rooms are expected to complete fit testing for the N95 respirator on an annual basis. Medical Staff who interpret tests requiring color discernment (e.g. dipstick of urine) should have normal color vision. YNHHS Occupational Medicine and Wellness Services (OMWS) Clinics are available to carry out N95 fit testing and Ishihara color vision screening for Medical Staff members at no charge. OMWS Clinics also are available at no charge to Medical Staff members who require additional vaccine doses or serological testing for vaccine response. Medical Staff members may contact OMWS at the following numbers:

YNHH YSC: 203-688-2462 (1<sup>st</sup> floor, YNHH YSC East Pavilion)

YNHH SRC: 789-3721 (175 Sherman Avenue, 5<sup>th</sup> floor)

Bridgeport Hospital 203-384-3613 (226 Mill Hill Ave # 2)

Greenwich Hospital 203-863-3400 (Watson Pavilion, 2<sup>nd</sup> floor)

L&M Hospital 860-442-0711, ext. 2289 (L&M Hospital)

Westerly Hospital 401-348-3783 (Westerly Hospital)