

**INSTRUCTIONS:** This form must be completed in its entirety, signed and stamped by a physician's office, then forwarded to OMS before the required pre-placement medical evaluation can be scheduled. Forms should be submitted to OMS either in person: Building 10 Room 6C306; by fax: 301-402-0673; or by email: [oms@mail.nih.gov](mailto:oms@mail.nih.gov)  
**NOTE:** This form is only to be used for Summer 2015

**NIH OCCUPATIONAL MEDICAL SERVICE  
DOCUMENTATION OF IMMUNIZATIONS- SUMMER 2015**

Name \_\_\_\_\_ SSN (Last 4) \_\_\_\_\_

Phone (Home and/or Cell) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**1. Tuberculosis (a PPD test administered on or after 9/1/14 is required)**

PPD Placed

\_\_\_\_ Yes \_\_\_\_ No Date Placed: \_\_\_\_\_

5 T.U. 0.1 ml ID \_\_\_\_ L \_\_\_\_ R forearm Mfg/Lot# \_\_\_\_\_

Result

Date: \_\_\_\_\_ Negative \_\_\_\_ Positive: \_\_\_\_ mm

or IGRA Blood test for TB

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_ Positive \_\_\_\_ Negative

For Any Positive Results (TST/IGRA)

Date of last chest x-ray \_\_\_\_\_

(Must be within 2 years; attach copy of x-ray report)

INH recommended \_\_\_\_ Yes \_\_\_\_ No

Duration of treatment \_\_\_\_\_

**2. Tetanus/Diphtheria**

Date of last booster \_\_\_\_\_ (Must be within 10 years) Tdap \_\_\_\_ Td \_\_\_\_

**3. Measles (Rubeola)**

Date of Immunizations (2 doses required) #1 \_\_\_\_\_ #2 \_\_\_\_\_

OR Provide documentation of positive titer (attach)

**4. Chickenpox (Varicella)**

Date of Immunizations (2 doses required) #1 \_\_\_\_\_ #2 \_\_\_\_\_

OR Provide documentation of either positive titer or history of disease (attach)

**5. Hepatitis B**

Date of Immunizations (3 doses required)

#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

OR Provide documentation of positive titer (attach)

Healthcare Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Provider's Address (or stamp)

\_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_