

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

NOTE: This form is only to be used for Summer 2019.

**NIH OCCUPATIONAL MEDICAL SERVICE
DOCUMENTATION OF IMMUNIZATIONS- SUMMER 2019**

Name _____ Last 4 # SSN _____
Phone: Cell _____ Home _____ Date of Birth: _____
Email: _____ NIH Institute or Center: _____

1. Tuberculosis (a PPD test administered on or after 9/1/18 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

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 _____