

Date:

To: NIH Employees

From: Medical Director  
Occupational Medical Service

Subject: Travel Immunizations

Employees going on work-related foreign travel with NIH travel orders may receive immunizations and medications from the Occupational Medical Service (OMS) based on their itinerary, immunization history, and current CDC recommendations. Please complete the attached "Travel Immunization Request" promptly and fax it to 402-0673 or bring or mail the request to the OMS clinic, Building 10, Room 6C306. A nurse will review the information and contact you directly regarding the recommended immunizations and/or medications. At that time an appointment will be made to start immunizations and/or travel medications.

In order to ensure a review of your **Travel Immunization Request** in time, this form should be submitted at least 2 weeks prior to your last day at NIH. You may require several immunizations over a number of weeks in order to achieve an appropriate level of protection. In the event you become ill or injured while on official travel or a travel-related medical problem develops after you return home, make an appointment at OMS to report the occurrence so that appropriate Workers' Compensations forms can be completed.

James M. Schmitt, M.D., M.S.

**TRAVEL IMMUNIZATION REQUEST FORM  
FOR WORK-RELATED TRAVEL ONLY**

To Be Completed By Traveler

Name: \_\_\_\_\_ SSN (last four digits): \_\_\_\_\_  
 Institute: \_\_\_\_\_ Bldg/Rm: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
 Have you previously visited OMS? No  Yes  Date of last visit: \_\_\_\_\_  
 Last day at NIH prior to departure: \_\_\_\_\_ (mm/dd/yy)

**Please list destination countries in chronological order. Specify city and any work-related side trips (jungle, rivers, etc.)**

COUNTRY / CITY	DATES

**Medical History**

Drug Allergies: \_\_\_\_\_  
Write "none" if applicable.

Current Medical Problems: \_\_\_\_\_  
Write "none" if applicable.

Current Medications: \_\_\_\_\_  
Write "none" if applicable.

Currently pregnant or breastfeeding? Yes \_\_\_\_\_ No

**Immunization History**

On file in OMS

or

Provide dates of most recent vaccination/test

Tetanus (Td/Tdap) \_\_\_\_\_ Yellow Fever \_\_\_\_\_ Hepatitis A (2\*) \_\_\_\_\_

Meningococcal \_\_\_\_\_ Typhoid \_\_\_\_\_ Hepatitis B (3\*) \_\_\_\_\_

Influenza \_\_\_\_\_ MMR (2\*) \_\_\_\_\_ Varicella (2\*) \_\_\_\_\_

Polio (adult booster injection) \_\_\_\_\_ TB skin test (PPD) \_\_\_\_\_

\* Number of vaccinations required to complete the series

Please submit completed form to OMS at least two weeks prior to travel – Fax: 301-402-0673  
 Forms will be processed without travel orders, however a copy of the Authorized orders must be submitted when ready.