New Hire Immunization Form

Full Name (please print)_____Job Title_____

Hospital Department/Unit_____ Employee ID Number_____

Date of Hire_____ Date of Birth_____ Gender (circle) ☐ ☐

Supervisor's Name & Signature_____

To prevent delay in processing of payroll forms, please return this form and all required documentation to your hiring department prior to your first day of work

Type of Immunization or Test	Where Immuni-zation or Test was Obtained	Date	Documenta-tion Attached * (Yes/No)	Health Care Provider Signature
TB Skin Test within 2 mos. of hire date** (record result in millimeters)				
MMR Dose #1 (or record positive titers for Measles and Rubella)				
MMR Dose #2 (or record positive titers)				
Tetanus-Diphtheria (within past 10 years)			***	
Hepatitis B Vaccine Dose #1			***	
Hepatitis Dose #2				
Hepatitis Dose #3 (record titer if available)				

Please answer/complete the following questions:

1. Have you ever had chickenpox****? (circle one) ☐ ☐
   If so, when did you have chickenpox (or how old were you)? _____(year or age)
2. Have you ever had a blood test to prove chickenpox immunity or have you received chickenpox immunizations? (circle one) Y ☐ N ☐
   If so, please attach documentation of immunity or immunizations.
3. Do you give direct patient care or do you come in direct contact with patients, specimens or soiled equipment? (circle one) Y ☐ N ☐

Please read and sign the following: University of Utah Hospitals and Clinics may verify all information listed on this form. I understand that being hired and continued employment depends on the truthfulness of this information.

Employee signature_____**Date**_____

Read and sign ONLY if all requirements CANNOT be met, e.g., due to a temporary or permanent medical exemption: I have not been able to fulfill these requirements due to _____
_____. I understand that failure to promptly receive the required immunizations when medically allowable could result in termination of my employment.

Employee Signature_____**Date**_____

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* Definition of "documentation" – photocopy of your medical record signed by your health provider.