

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

(Please include all 9-digits)

<b>MEASLES VACCINES OR 2 MMR</b> (1 <sup>st</sup> Vaccination after 1 <sup>st</sup> Birthday)		<b>OR</b>	<b>MEASLES/RUBEOLA ANTIBODY</b>
Date 1: ____ / ____ / ____	Date 2: ____ / ____ / ____		Date: ____ / ____ / ____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>MUMPS VACCINE OR 2 MMR</b>		<b>OR</b>	<b>MUMPS ANTIBODY</b>
Date 1: ____ / ____ / ____	Date 2: ____ / ____ / ____		Date: ____ / ____ / ____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>RUBELLA VACCINE OR 1 MMR</b>		<b>OR</b>	<b>RUBELLA ANTIBODY</b>
Date: ____ / ____ / ____			Date: ____ / ____ / ____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>HEPATITIS B</b> (FOR 'AT RISK' HCW)	<b>HEPATITIS B VACCINE</b>	<b>AND</b>	<b>HEPATITIS B ANTIBODY</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Date 1: ____ / ____ / ____ Date 2: ____ / ____ / ____ Date 3: ____ / ____ / ____		Date: ____ / ____ / ____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>CHICKEN POX - ACTIVE DISEASE</b>	<b>VARICELLA VACCINATION</b>	<b>OR</b>	<b>VARICELLA ANTIBODY</b>
<input type="checkbox"/> Yes - Documented Proof Date: ____ / ____ / ____	Date 1: ____ / ____ / ____ Date 2: ____ / ____ / ____		Date: ____ / ____ / ____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>OR</b>			
<b>2 MANTOUX TB SKIN TESTS (THE DATE WITHIN IS 12 MONTHS &amp; 60 DAYS FROM START DATE)</b>			
<b>OR</b>			
<b>1 IGRA/TB LAB TEST (QUANTIFERON GOLD OR T-SPOT) WITHIN 12 MONTHS (ATTACH LAB RESULT)</b>			
Date 1 Apply: ____ / ____ / ____ (Date 1 within 12 months)	Date 2 Apply: ____ / ____ / ____ (Date 2 within 60 days of start date)	Results: Date Read: __/__/____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ mm Results: Date Read: __/__/____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ mm <b>If Positive: Documentation of TB test with measurement required. Chest X-Ray within 3 years of Start/Hire date required. WFBMC TB Questionnaire required.</b>	
<b>OTHER PERTINENT HEALTH HISTORY</b>			
<b>Tetanus booster OR Tdap within past 10 years</b>			
Tetanus _____ Tdap _____ Date: ____ / ____ / ____			
<b>Seasonal Influenza Vaccine</b> Date: ____ / ____ / ____			

To my knowledge, this individual is free from communicable diseases that could pose significant risk to the health and safety of others, and has no physical or mental conditions that would prevent him/her from performing the essential duties required with or without reasonable accommodations.

\_\_\_\_\_  
**Signature of Health Care Provider OR Stamp of Health Care Provider Clinic**

\_\_\_\_\_  
**Date Signed/Stamped**