IMMUNIZATION DATA:

Please indicate the date (mm/dd/yy) of immunization for each of the following:

Hepatitis B
1. __________/_________/_________
2. __________/_________/_________
3. __________/_________/_________

Measles/Mumps/
Rubella
________/_________/_________

Chicken Pox
________/_________/_________

TEST DATA:

Date of Last
TB Skin Test
________/_________/_________
Results - positive or negative (circle one)

(Hospital regulations require TB testing within six months of reporting for duty and every year thereafter while in training.)

________/_________/_________
Date Signed

Signature of Resident Physician

___________________________________
PRINT Full Name

________/_________/_________
Date Resident/Fellow is expected
to complete training in this program.