



Burapha University Hospital

Immunization & Health Screening Record for Visiting Healthcare Personnel

Instructions:

To ensure the safety of our patients, staff, and visitors, all visiting healthcare personnel with anticipated patient contact must provide proof of immunity to the diseases listed below. This form must be completed and submitted with all required supporting documents (e.g., laboratory reports, official vaccination records) prior to commencing any clinical activities. All documentation must be in English.

Please note that the visitor is responsible for all costs associated with required laboratory testing and vaccinations.

Part 1: Personal Information

Full Name:

Date of Birth (DD/MM/YYYY):

Passport / ID Number:

Home Institution:

Visiting Department:

Dates of Visit (From - To):

Part 2: Immunization & Immunity Status

Please complete each section below, select the option that applies to you and attach the required proof:

1. Hepatitis B Virus (HBV)

- A lab report showing anti-HBs ≥ 10 mIU/mL

2. Varicella (Chickenpox)

- A lab report showing positive Varicella IgG, **OR**
- Documentation of a 2-dose vaccination series, **OR**
- A medical certificate confirming a past history of chickenpox.

3. Measles, Mumps, and Rubella (MMR)

- Documentation of a 2-dose MMR vaccination series, **OR**
- Lab reports showing positive immunity (IgG) for Measles, Mumps, AND Rubella.

4. Tetanus, Diphtheria, Pertussis (Tdap)

I have attached documentation of a Tdap vaccine booster received within the last 10 years.

5. Influenza (Flu)

I have attached documentation of a annual influenza vaccine received within the last 1 years.

Part 3: Additional Remarks / Medical Exemptions

If you are unable to comply with any of the above immunization requirements due to a medical contraindication (e.g., allergy, pregnancy, immunosuppression), please provide a detailed explanation below. A signed letter from your physician detailing the reason for exemption is required.

Remarks:

Supporting medical documentation is attached.

Part 4: Declaration

I hereby declare that the information provided on this form and in the attached documents is true and accurate to the best of my knowledge.

Signature: _____

Printed Name: _____

Date: _____

Part 5: For Official Use Only

All requirements met. Cleared for patient contact.

Follow-up required. Specify: _____

Reviewed by: _____

Title: _____

Date: _____