Arbeitsmedizin Neuromed Campus
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Kepler Universitäts Klinikum

Immunization for Health Care Workers
at the Kepler Universitätsklinikum

We ask you to complete this questionnaire as soon as possible and send it to **Arbeitsmedizin** with a **copy of your vaccination record and digital COVID certificates.**

name:	**social security number / date of birth**	
	planned activity:	**Date from:**
adress:	**department:**	**Date to:**
	course / vintage:	
mobile phone:		
private email:	**training site:**	

Mandatory vaccinations	**date of immunization**	**vaccination recommended**
Measles – Mumps - Rubella (two dose vaccine required)	1. Immunization 2. Immunization	Yes ☐ No ☐
No two dose vaccination, serological testing is required	Immunity to Measles: Immunity to Mumps: Immunity to Rubella:	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Varicella	History of disease - Date: Immunity to varicella:	Yes ☐ No ☐
No history of disease, serological testing neg	1. Immunization varicella 2. Immunization varicella	Yes ☐ No ☐

Hepatitis B (at least 3 dose vaccination) Name of vaccine:	1. Immunization 2. Immunization 3. Immunization Booster Injection: Serological testing:	Yes ☐ No ☐ Next due vaccination:

Recommended vaccinations	**Last date of immunization**	**vaccination recommended**
Covid-19 **Name of vaccine:**	Validity vaccination certificate / digital COVID certificates until_____ Vaccination ☐ recovered ☐	Yes ☐ No ☐ Next due vaccination:
Pertussis		Yes ☐ No ☐
Poliomyelitis		Yes ☐ No ☐
Diphterie		Yes ☐ No ☐
Tetanus		Yes ☐ No ☐
Hepatitis A Name of vaccine:	1. Immunization 2. Immunization	Yes ☐ No ☐

Medical confirmation:

I hereby confirm sufficient immunity against

☐ **Measles/Mumps/Rubella** ☐ **Hepatitis B**

☐ **Varicella**

I hereby confirm the accuracy of the information on the voluntary vaccination records.

Date: …… Signature and stamp of the physician: ……

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