

Proof of Immunization for Health Care Workers at the Kepler Universitätsklinikum

- Med Campus II., Krankenhausstraße 7a, 4020 Linz
- Med Campus III., Krankenhausstraße 9, 4021 Linz
- Med Campus IV., Krankenhausstraße 26-30, 4020 Linz

Please send the completed and signed form **no later than 8 weeks** before the start of your internship to ARBEITSMEDIZIN at the Kepler Universitätsklinikum.

Please fill in mandatory:

<p>Surname:</p> <p>First name:</p> <p>Address:</p>	<p>Please mark as appropriate:</p> <p><input type="checkbox"/> compulsory internship <input type="checkbox"/> holiday work</p> <p><input type="checkbox"/> voluntary placement <input type="checkbox"/> clerkship</p> <p><input type="checkbox"/> leasing force <input type="checkbox"/> student</p> <p><input type="checkbox"/> hospitable doctor</p> <p><input type="checkbox"/> Other: _____</p>	
<p>Social security number/Date of birth:</p>	<p>Start date:</p>	<p>End date:</p>
<p>Mobile phone number:</p> <p>E-mail:</p>	<p>Planned activity:</p> <p>Department:</p>	
<p>Home university:</p>	<p>Contact person/internship carer at the Kepler Universitätsklinikum:</p>	

Mandatory vaccinations	Date of immunization	Vaccination recommended			
Measles – Mumps – Rubella (two dose vaccine required)	1. Immunization	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	2. Immunization	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If you don't have a two dose vaccination, serological testing is required	Immunity to Measles:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Immunity to Mumps:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Immunity to Rubella:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Varicella	History of disease - Date:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Immunity to varicella:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If there is no history of disease or if the serological testing is negative	1. Immunization varicella	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	2. Immunization varicella	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Hepatitis B (At least 3 dose vaccination) Name of vaccine:	1. Immunization	Yes <input type="checkbox"/> No <input type="checkbox"/> Next vaccination due on:
	2. Immunization	
	3. Immunization	
	Booster Injection:	
	Serological testing:	

Recommended vaccinations	Last date of immunization	Vaccination recommended
Pertussis		Yes <input type="checkbox"/> No <input type="checkbox"/>
Poliomyelitis		Yes <input type="checkbox"/> No <input type="checkbox"/>
Diphtherie		Yes <input type="checkbox"/> No <input type="checkbox"/>
Tetanus		Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis A Name of vaccine:	1. Immunization 2. Immunization	Yes <input type="checkbox"/> No <input type="checkbox"/>

Physician's confirmation:

I hereby confirm sufficient immunity against

- Measles/Mumps/Rubella,**
- Varicella and**
- Hepatitis B.**

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

Date:

Signature and stamp of the physician: