Arbeitsmedizin Med Campus
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Kepler Universitäts Klinikum

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

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

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:	Yes ☐ No ☐
	Immunity to Mumps:	Yes ☐ No ☐
	Immunity to Rubella:	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 Impfstoff:	1. Impfung 2. Impfung	Ja ☐ Nein ☐
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,**

☐ **Varicella** und

☐ **Hepatitis B**.

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

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

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