Contracted Health Care Worker Examination and Immunization Verification Form

Infectious Disease	Dates (DD-MM-YYYY)	Proof of Immunity
Varicella (chickenpox)*	1. ☐☐-☐☐-☐☐☐☐ 2. ☐☐-☐☐-☐☐☐☐	Physician documented history of varicella (attach)
Measles*	1. ☐☐-☐☐-☐☐☐☐ 2. ☐☐-☐☐-☐☐☐☐	Positive IgG titer date ☐☐-☐☐-☐☐☐☐
Mumps*	1. ☐☐-☐☐-☐☐☐☐ 2. ☐☐-☐☐-☐☐☐☐	Positive IgG titer date ☐☐-☐☐-☐☐☐☐
Rubella*	1. ☐☐-☐☐-☐☐☐☐ 2. ☐☐-☐☐-☐☐☐☐	Positive IgG titer date ☐☐-☐☐-☐☐☐☐
Tetanus (T, Td, Tdap)*	☐☐-☐☐-☐☐☐☐	
Diphtheria (Td, Tdap)*	☐☐-☐☐-☐☐☐☐	
Pertussis (Tdap)*	☐☐-☐☐-☐☐☐☐	
Influenza (seasonal) (all HCWs)	☐☐-☐☐-☐☐☐☐	
Tuberculosis (all HCWs with negative history of TB or exposure)	1. ☐☐-☐☐-☐☐☐☐ 2. ☐☐-☐☐-☐☐☐☐ } 2-52 weeks apart Result (circle one): Negative Positive	Blood assay for *M. tuberculosis* date ☐☐-☐☐-☐☐☐☐ Result (circle one): Negative Positive
Tuberculosis (all HCWs with positive history of TB or exposure)	Latent TB infection prophylaxis? Year ☐☐☐☐ started or complete (circle one)	CXR date ☐☐-☐☐-☐☐☐☐ Result (circle one): Negative Positive
Hepatitis B (only applies to HCWs with potential occupational exposure to bloodborne pathogens)	1. ☐☐-☐☐-☐☐☐☐ 2. ☐☐-☐☐-☐☐☐☐ 3. ☐☐-☐☐-☐☐☐☐ If necessary (i.e., if first titer negative): 4. ☐☐-☐☐-☐☐☐☐ 5. ☐☐-☐☐-☐☐☐☐ 6. ☐☐-☐☐-☐☐☐☐	IgG (HBsAb) titer date ☐☐-☐☐-☐☐☐☐ Result (circle one): Negative Positive IgG (HBsAb) second titer date ☐☐-☐☐-☐☐☐☐ Result (circle one): Negative Positive Counseling provided date (if repeat titer negative) ☐☐-☐☐-☐☐☐☐
Other (identify)	☐☐-☐☐-☐☐☐☐ ☐☐-☐☐-☐☐☐☐	
Latex sensitivity screening	☐☐-☐☐-☐☐☐☐	History IS / IS NOT (circle one) consistent with latex sensitivity

* Applies only to HCWs with direct patient contact.

I certify that _____ was examined on ☐☐-☐☐-☐☐☐☐ and WAS / WAS NOT found to
name of health care worker *mm dd yyyy* *cicle one*
be in good health, meeting the immunization and screening required above, and free of any medical condition or infectious disease that may prevent his/her ability to perform services as a Health Care Worker.

Provider's Signature: _____ Provider's Name: _____

Phone Number: _____ Date: _____

This section for Navy use only

Completed form and accompanying documentation reviewed and found complete.

Reviewer's signature _____ Name (print) _____ Date _____