Postdoctoral Fellow Patient Care Information Sheet
Required for all MD's

Name____
Last First Middle Initial

I confirm that the above referenced physician will have:

No patient contact during the fellowship at Stanford Hospital/Clinics. _____ (initial)
(Faculty Sponsor and Fellow must sign form. Do not complete any other portion of the information sheet)

May have incidental patient contact during his/her fellowship. _____ (initial)

Full patient care responsibilities of a clinical fellow _____ (initial)

This position is an **ACGME/ABMS** accredited fellowship. Yes_____ No_____

Will a request for billing privileges be submitted for the above referenced physician? Yes_____ No_____
(If yes, attach the Agreement for Services Outside the Fellowship and include the "billing paragraph" in offer letter.) Stanford does not allow ACGME fellows to bill for services. For fellows in "non-approved" programs, billing is restricted to services not in their areas of training.

Complete for any type of patient care:

Social Security #:______________________________

Specialty:____

Postgraduate Year: I_____ II_____ III_____ IV_____ V_____ Other_____

California Medical License #:________________________ Expiration Date:________________

Medical School:________________________________ Date Graduated:________________
mm/dd/yyyy

Attach a copy of the medical school diploma (and if an international medical school graduate a copy of the ECFMG certificate), and a copy of the California Medical License showing the expiration date.

Previous Training: Specialty Location

PGY I ______________________________________ Dates________________

PGY II ______________________________________ Dates________________

PGY III______________________________________ Dates________________

PGY IV ______________________________________ Dates________________

PGY V ______________________________________ Dates________________

Fellow's Signature: ________________________________ Date: _______________

______________________ ______________________________

PRINT NAME **Signature of faculty sponsor/program director, title and date**

[Postdoctoral Services Office only]

Term of appointment:________________________________ **Postdoctoral Approval**:_______
Date of fax:

IMMUNIZATION RECORD
SCHOOL OF MEDICINE POSTDOCTORAL FELLOWS WITH PATIENT CONTACT

If you do not obtain the required immunizations, you may be placed on Medical Hold, which will prevent disbursement of your stipend/fellowship support and access to campus facilities.

Note: If you do not obtain the below immunization before arriving at Stanford, they are available through COWELL STUDENT HEALTH for a fee. These fees are your responsibility except for the Hepatitis B vaccine series, which is paid by the Medical School for you.

Name: ____ | ____________________

Last First Middle Birthdate

VACCINE	DATE	COWELL USE ONLY
MEASLES, MUMPS, RUBELLA (MMR) twice, or *All* of the below	#1 ___/___/___ #2 ___/___/___	
Measles (rubeola)		
either 1. Two vaccinations ☐	#1 ___/___/___ #2 ___/___/___	
or 2. Physician documented disease (MD signature required) _______________________________MD		
or 3. Laboratory evidence of disease immunity: ☐	___/___/___	
Mumps		
either 1. Vaccination ☐	___/___/___	
or 2. History of disease ☐	___/___/___	
or 3. Laboratory evidence of disease immunity ☐	___/___/___	
Rubella (German Measles)		
either 1. Vaccination (after 1969) ☐	___/___/___	
or 2. Laboratory evidence of disease immunity: ☐	___/___/___	
VARICELLA (Chicken pox)		
either 1. Two vaccinations ☐	#1___/___/___ #2___/___/___	
or 2. Laboratory evidence of disease immunity ☐ (MD signature required) ______________________MD	___/___/___	
HEPATITIS B		
1. Three (3) Hepatitis B vaccinations and	#1___/___/___ #2___/___/___ #3___/___/___	
2. Documentation of positive antibody to hepatitis B (MD signature required) ______________________MD		
TUBERCULOSIS screening (yearly)		
either 1. Tb skin test Type ☐ Result ☐	___/___/___	
or 2. Chest X-Ray Result ☐	___/___/___	
or 3. Chest X-Ray brought from home country ☐ taken on:	___/___/___	

Date	Signature of Person Providing Above Information

Return completed/signed form to
Office of Postdoctoral Affairs
CCSR Building, Room 4235
Stanford University School of Medicine
Stanford, CA 94305 Mail Code: 5173
For questions please call: (650) 498-7618

POSTDOCTORAL IMMUNIZATION REQUIREMENTS

Tetanus and Diphtheria Immunity	Provide the following information: ✓**Date must include month and year** (a) Date of adult tetanus and diphtheria (Td) immunization within the past 10 years. *If you have not had a Td immunization in the past 10 years, you will need to do so now.	Cost at Vaden Health Center for: • Td Immunization $35.00
Measles Immunity (Rubeola)	✓**Date must include month and year** (a) Date of measles vaccinations (two doses) (or date of combined measles, mumps and rubella vaccination). **-or-** (b) Date and physician's signature of physician diagnosed measles **-or-** (c) Date and titer results of serology	Cost at Vaden Health Center for: • MMR Immunization $20.00 • Measles Titer $39.00
Mumps Immunity	If you were born after *1956,* provide the following information: ✓**Date must include month and year** (a) Date of mumps vaccination (or date of combined measles, **- or-** (b) Date of history of disease **-or-** (c) Date and titer results of serology. *If you have not obtained either of these, you will have to do so now.	Cost at Vaden Health Center for: • MMR Immunization $20.00 • Mumps Titer $40.00
Rubella Immunity (German measles)	✓**Date must include month and year** (a) Date of mumps vaccination after 1969 (or date of combined measles, mumps and rubella vaccinations) **-or-** (b) Date and titer results of serology, *If you have not obtained either of these, you will have to do so now.	Cost at Vaden Health Center for: • MMR Immunization $20.00 • Rubella Titer $24.00
Varicella Immunity (Chicken Pox)	✓**Date must include month and year** (a) Date of Varicella vaccinations (two doses) **-or-** (b) Date and titer results of serology. Must have M.D. signature. *If you have not obtained either of these, you will have to do so now.	Cost at Vaden Health Center for: • Varicella Immunization $82.00 • Varicella Titer $41.00
Hepatitis B Immunitiy	(a) Dates of three immunizations, followed by, (b) Date and titer results of serology. Must have MD signature. Note: It takes seven months to complete this Immunization requirement.	Cost at Vaden Health Center for: • Hepatitis B Immunization $42.00 • Hepatitis B Titer $38.00
Tuberculosis (TB) Testing **Test must be repeated annually.**	✓**Date must include month and year** (a) Date, type of test and result of most recent TB test (result must be in millimeters). • **If your test results were positive**, (reaction of 10 millimeters or greater) or if you have ever been treated for Tuberculosis a repeat test is not necessary. • **However**, you must provide the date and result of your diagnostic X-ray and include a copy of the X-ray report. The X-ray must have been done in the US or Canada only. No other countries are acceptable.	Cost at Vaden Health Center for: • TB test $18.00 • Chest X-ray $60.00

These may be obtained at Vaden Health Center Injection Clinic. For Appoinments please call: (650) 498-2336, extension 1.