Indiana University School of Medicine
Health Requirements for Beginning GME Training

For the protection of IUSM GME trainees and the patients with whom they will come in contact during training, all trainees must meet established health requirements. Please contact your physician (if needed) as soon as possible to begin completing the requirements outlined below. **HEALTH FORMS ARE DUE on or before your start date.**

Please print the Health Evaluation and Immunization forms, have them completed and signed by your physician and send or deliver to your training program coordinator.

(**Please keep a photocopy of all forms for your records**. **If you have been assigned to a Center other than Indianapolis, please submit a photocopy to your Center Director's office; many of you will need this for your host institution.) If you have questions regarding these requirements, please call the Student Health Center, (317) 274-5887.**

1. Immunization Form. It is imperative that you have certain immunizations completed prior to beginning your training program because of the direct patient contact you will encounter during your professional training. The appropriate information should be properly recorded by your physician on the immunization form. Below is a description of the immunizations that are required for your matriculation in the School.

Tetanus Diphtheria (Td). All students must be immunized **every ten (10) years**.
Tetanus, Diptheria and Pertussis (Tdap). One lifetime booster containing Pertussis is required.

Rubella (German measles). All trainees are required to have either a rubella titer **or** receive rubella vaccine. (The current standard at Indiana University School of Medicine is that rubella immunization is required if the titer indicates susceptibility, i.e., lack of detectable antibody.)

Rubeola (measles). Persons born after 1956 must show evidence of receipt of two doses of measles vaccine after 12 months of age, or show proof of immunity (by titer or physician diagnosed disease).

Mumps. All trainees are required to be immunized with one dose of mumps vaccine or show proof of a positive titer.

Polio. All trainees are required to show evidence of completing the primary polio series.

Tuberculosis. All trainees must have a PPD Tuberculin skin test **within three months prior to the beginning of training**. The test must be read and documented by medical personnel. If you had a positive PPD skin test in the past, you must provide documentation of the positive result and any chest x-rays you had or medical treatment you received because of it. If you have a newly positive reaction to the skin test, a chest x-ray is required and the results must be recorded on the immunization form. Your physician should indicate what treatment, if any, has been prescribed for you as a result of a positive skin test or chest x-ray. If you have received a BCG, you must have a TB skin test unless you have documented proof of a positive TB skin test. (Note: A new PPD will be required at the beginning of each subsequent year of medical school.)

Varicella (Chicken pox). All trainees are required to provide either a) medical records documentation of the diagnosis of chicken pox or zoster, or b) a positive titer, or c) two varicella vaccines.

Hepatitis B. Immunization against Hepatitis B is mandatory for your protection. You will be at increased risk because of your contact with patients. The vaccine is administered in a series of three injections at 0, 1, and 6 months. Trainees must provide documentation of completion of the series prior to beginning of training. Trainees who are unable to complete the series prior to starting training may bring the remaining vaccine to the Student Health Service for storage and future administration. However, **all trainees must show evidence of having begun the series** at the time this form is due in the Office of IUSM Office of Graduate Medical Education.

Please keep a photocopy of all completed forms for your records and for future reference.
INCOMPLETE FORMS ARE **NOT** ACCEPTABLE AND WILL BE RETURNED.

Indiana University School of Medicine
IUSM GME Office
Required Immunizations and Screening
IUSM GME Office

Name (please print) ____ **Gender**_______
Last First MI

Social Security Number________________________ **Birthdate**______________ **Current Date**________________

1. **Rubella**. (German Measles) Immunization **OR** proof of positive titer. Immunization Date________________________
   Titer results/Date ________________________

2. **Rubeola**. (Measles). Anyone born after December 31, 1956 must document proof of 2 measles vaccines (M, MR, MMR). The first vaccine must have been administered on or after 12 months of age and must be a live virus vaccine. History of disease is not considered proof of immunity, unless a physician has diagnosed measles (documentation required). A positive antibody titer to measles is acceptable as proof of immunization.
   Immunization 1 Date ________________________
   Immunization 2 Date________________________
   Titer results/Date ________________________
   History of disease/Date ________________________

3. **Mumps**. Immunization **OR** proof of positive titer. Immunization Date ________________________
   Titer results/Date ________________________

4. **Polio**. Date primary series completed. Date series completed ________________________

5. **Tuberculosis**. (PPD) screening. Must be **within 3 months prior to beginning of training program (Note: the test must be read 48-72 hour window after it is placed)**

   Date placed ______________ time ________ Date read ______________ time ________ Reading ________________
   (month/day/year) (time am/pm) (month/day/year) (time am / pm) (mm)

   If there is a past history of a positive PPD, a chest x-ray will be required.

6. **Varicella**. (Chicken pox). Physician diagnosis of chicken pox or zoster -(enclose proof)
   OR have proof of a positive titer Titer results/Date________________________
   OR have 2 doses of varicella vaccine Immunization 1 Date ________________________
   Immunization 2 Date ________________________

7. **Hepatitis B vaccine**. **OR** Titer results/Date Dates of administration: 1 ________________________
   2 ________________________
   3 ________________________

8. **Tdap – Tetanus, Diphtheria and Pertussis** One as an adult Immunization Date________________________

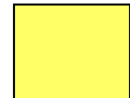
9. **Tetanus, Diphtheria – Td**. Must be within the last 10 years Immunization Date________________________

Physician's name (please print) ________________________________ Date ____________________

Office phone number ________________Office address ________________________________

Physician's Signature ____

Note: Please be advised that immunization information, if requested, will be provided to training facilities without additional written consent from the trainee. After reading this statement, place your (trainee) initials in this box.



This form must be mailed or delivered to your program coordinator on or before **your start date.**

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