MAYO CLINIC

Post Offer Immunization and Communicable Disease

OHS Staff Use Only –
- ☐ Allied Health
- ☐ Mayo Graduate School
- ☐ Mayo School of Graduate Medical Education
- ☐ Mayo School of Health Sciences
- ☐ New Consultant Staff
- ☐ Research Services
- ☐ Other

Name (First Name, Middle Initial, Last Name)	Mayo Clinic Number (If Known)
U.S. Social Security Number	Birth Date *(Month DD, YYYY)*
Home Phone (Including Area Code)	Work Phone (Including Area Code)

For the protection of patients, employees, students, volunteers and visitors, and in compliance with state and federal regulations, Mayo Clinic requires immunization against certain vaccine preventable diseases. Mayo Clinic also has a comprehensive plan to reduce the risk of tuberculosis transmission which involves a screening process for all applicants.

Enter the month/day/year for **ALL** doses of **ALL** vaccines. Note the date and age if you have had a disease or the date and result if you had a serology (blood test) done. **Please provide documentation at the time of your appointment.** Also complete page 2 of this form.

Vaccine Description	If you have had the vaccination, provide the month/day/year of each vaccination.	If you had the disease: Date and Age	If you had the disease: Health Care documentation provided?	If you had a serology (blood test) provide month/date/year and results: Test Date	Test Result
Hepatitis B	1 2 3 / 4 5 6		☐ Yes ☐ No		
Measles (rubeola, red measles, 7-day measles)	1 2 3		☐ Yes ☐ No		
Mumps	1 2		☐ Yes ☐ No		
Rubella (German measles, 3-day measles)	1		☐ Yes ☐ No		
OR					
MMR (measles, mumps, rubella vaccine)	1 2	**NA**	**NA**		
DPT (diphtheria-pertussis-tetanus)	Have you had your entire primary DPT series? ☐ Yes ☐ No	**NA**	**NA**		
TD (tetanus-diphtheria) booster	most recent date	**NA**	**NA**		
Tdap (adult tetanus-diphtheria-pertussis-)	1	**NA**	**NA**		
Hepatitis A	1 2		☐ Yes ☐ No		
Chicken Pox (varicella)	1 2		☐ Yes ☐ No		
Influenza	1		☐ Yes ☐ No		
Rabies vaccine	1 2 3	**NA**	**NA**		
Smallpox		**NA**	**NA**	MajorTake ☐ Yes ☐ No	
Meningococcal	1 2 3	**NA**	**NA**		

OHS Staff Use Only

Vaccines Needed								Tests Ordered								Infectious Hazard ☐ Yes ☐ No
HBV				MMR		Tdap	TD	TST		BAMT / IGRA	CXR	HBsAb	Rubeola	Mumps	Rubella	Varicella	
			Decl														Start Date *(Month DD, YYYY)*
Other Vaccines								Other Tests									
RN Signature								Signature Date *(Month DD, YYYY)*									

MC0424-04rev0913

Assessment of Tuberculosis Status

Tuberculin Skin Test (TST, Mantoux) Have you received a live virus vaccine in the last 4 weeks? (MMR, Varicella, Flu Mist) ☐ Yes ☐ No	1st Test Date *(Month DD, YYYY)*	Reaction Size mm	Documentation Provided ☐ Yes ☐ No
	2nd Test Date *(Month DD, YYYY)*	Reaction Size mm	Documentation Provided ☐ Yes ☐ No
	If TST is positive, Date of Last Chest X-ray *(Month DD, YYYY)*	Chest X-Ray Results ☐ Negative ☐ Positive	X-Ray Documentation Provided ☐ Yes ☐ No
Blood Assay Mycobacterium test (Quanti-FERON, BAMT/IGRA Quanti-FERON Gold)	Test Date *(Month DD, YYYY)*	Results ☐ Negative ☐ Positive ☐ Indeterminate	Documentation Provided ☐ Yes ☐ No
Were you given any medications related to a positive Tuberculin Skin Test? ☐ Yes ☐ No	If yes, list dates *(Month DD, YYYY)*	List medications	

Yes	No	
		1. Do you currently have one or more of the following symptoms? (Check all that apply)
☐	☐	a. a cough that has lasted three or more weeks?
☐	☐	b. bloody sputum?
☐	☐	c. night sweats?
☐	☐	d. unexpected weight loss?
☐	☐	e. loss of appetite?
☐	☐	f. fever?

If you have answered yes to any questions for a. through f., please answer the following additional questions.

Yes	No	
☐	☐	2. In the last 12 months, have you been exposed to anyone with tuberculosis?
☐	☐	3. In the last 12 months, have you traveled outside the United States? If yes, what country_____ Length of stay_____
☐	☐	4. Were you born outside of the United States? If yes, what country_____
☐	☐	5. Have you ever had a prior "positive" Tuberculin (TB) skin test?
☐	☐	6. Have you been treated for tuberculosis?
☐	☐	7. Have you experienced an ulceration or open weeping sore at the injection site of a prior TB skin test?
☐	☐	8. Do you agree to return to have this test read within the required time of 48 to 72 hours?
☐	☐	9. Do you understand that "self-reading" of the test is not acceptable according to the Center for Disease Control (CDC) guideline?

Assessment of Active Communicable Diseases

Yes	No	
☐	☐	1. Do you have a draining sore or wound?
☐	☐	2. Do you have a skin rash?
☐	☐	3. Have you had any exposure to a contagious disease in the past two weeks?
☐	☐	4. Do you currently have a communicable disease for which you are being treated?

If you have answered yes to any of the above questions please provide a brief explanation.

Comments

I certify that the above information is true, and understand that this record will become part of my Occupational Health Services file.

Applicant Signature	Date *(Month DD, YYYY)*