INSTRUCTIONS: This form must be completed in its entirety, signed and stamped by a physician's office, then forwarded to OMS before the required pre-placement medical evaluation can be scheduled. Forms should be submitted to OMS either in person: Building 10 Room 6C306; by fax: 301-402-0673; or by email: oms@mail.nih.gov
NOTE: This form is only to be used for Summer 2020.

NIH OCCUPATIONAL MEDICAL SERVICE
DOCUMENTATION OF IMMUNIZATIONS- SUMMER 2020

Name _____ **Last 4 # SSN** _____

Phone: Cell _____ Home _____ **Date of Birth:** _____

Email: _____ **NIH Institute or Center**: _____

1. **Tuberculosis** *(a PPD test administered on or after **9/1/19** **is required**)*
   PPD Placed
   ☐ Yes ☐ No Date Placed: _____
   5 T.U. 0.1 ml ID: ☐ L ☐ R forearm. Mfg/Lot# _____
   Result
   Date: _____ ☐ Negative ☐ Positive: _____mm
   IGRA Blood test for TB
   Type: _____ Date: _____ Results: ☐ Positive ☐ Negative
   For Any Positive Results (TST/IGRA):
   Date of last chest x-ray _____
   (Must be within 2 years; attach copy of x-ray report)
   INH recommended ☐ Yes ☐ No Duration of treatment _____

2. **Tetanus/Diphtheria**
   Date of last booster _____ *(Must be within 10 years)* ☐ Tdap ☐ Td

3. **Measles (Rubeola)**
   Date of Immunizations *(2 doses required)* #1 _____ #2 _____
   OR Provide documentation of positive titer (attach)

4. **Chickenpox (Varicella)**
   Date of Immunizations *(2 doses required)* #1 _____ #2 _____
   OR Provide documentation of either positive titer or history of disease (attach)

5. **Hepatitis B**
   Date of Immunizations *(3 doses required)*
   #1 _____ #2 _____ #3 _____
   OR Provide documentation of positive titer (attach)

Healthcare Provider's Signature _____ **Date** _____

Printed Name _____

Provider's Address (or stamp)

_____

_____

Phone _____