St. Vincent's Medical Center

Research Associates Program Immunization Requirements

Name _____ DOB _____ SS# _____

St. Vincent's Medical Center requires that all students provide proof of immunity or vaccination from their Health Care Provider for the following diseases:

1. German Measles

Rubella Vaccine Date _____

OR

Rubella Titer Date _____ Result _____

2. Measles

Measles Vaccine

1st Dose Date (after 1/1/69) _____

2nd Dose Date (after 1/1/80) _____

OR

Measles Titer

Date _____ Result _____

3. Mumps

Mumps Vaccine Date _____

OR

Mumps Titer Date _____ Result _____

4. Tetanus/Diphtheria

Td Vaccine – Required every 10 years

Date _____

5. Hepatitis B

Hep B vaccine 1st dose Date _____

2nd dose Date _____

3rd dose Date _____

and

Antibody Titer Date _____ Result _____

You may opt out of the Hepatitis B vaccine and/or Antibody titer by signing the Hepatitis B Declination at Training

6. Meningitis

Meningococcal Vaccine - Optional

Date _____

8. Tuberculosis

Mantoux PPD (**within 12 months**)

Date _____

Result **N** **P** _____ **mm**

PPD + obtain CXR

Result _____ Date _____

Prophylactic Therapy

Medication(s) _____

Length of Time _____

7. Chickenpox

(N.B., history of Varicella is **NOT** sufficient)

Varicella Titer Date _____ Result _____

or

Varicella Vaccine Date _____

Varicella Vaccine Date _____

Vaccinations, titers and/or PPD needed for prospective RAs entry into the program may be obtained from their Health Care Provider or at St. Vincent's Immediate Health Centers (IHCC).

The prospective RAs will be responsible for these fees.
e.g., at the IHCC: Chickenpox/Varicella titer ($64), Hepatitis B surface antibody titer ($64), PPD ($15)

The RA Program pays for drug testing as part of the application fee.

The two things most commonly preventing RAs from starting on time:
1. no Varicella titer or vaccine and 2. no TB skin test / PPD within 12 months

I acknowledge completing the above required immunization/immunity testing on _____ (date).

Health Care Provider's Signature _____

Health Care Provider's Name _____

Address _____ **Phone** _____

OFFICE SEAL OR STAMP

When completed, please bring this form and a photo ID with you to your health assessment at either:

- Monroe Immediate Health Center - 401 Monroe Turnpike. Monroe, CT 06468-2276 (203) 268-250
- Shelton Immediate Health Center - 2 Trap Falls Road, Shelton, CT 06484-4665 (203) 929-1109)

You will be providing urine for a drug screen during this health assessment.

1 April 09