



PERSONAL INFORMATION:

Name

Date of Birth Nationality E-mail

Program Department

Program Start Date

Attach Documentation or Proof of Immunizations or Titers :

Please check the appropriate box that documents immunity. Also give dates in appropriate column.

Date of Positive Ab Titer
or Immunization

1. Mumps-Measles-Rubella (MMR) *

*records of prior infection is not sufficient

-
- Dated on

2. Varicella (chickenpox)

-

For Ab screening:

- Dated on
- The result:
 - Regarding be Negative IgG Ab; immunization done, Specify the date of immunization

3. Tetanus/Diphtheria (dT due q 10 years)

- Immunization dated on

4. Hepatitis Series

(Hepatitis C virus, HCV and Hepatitis B virus, HBV) and HBV vaccination is recommended, if indicated.

- Screening dated on
- HBsAg
- Anti HBs
- Anti HCV

<p>5. COVID-19 VACCINATION (Attached document certificate approved is required)</p>	<ul style="list-style-type: none"> • Vaccinated Date of 1st dose Date of 2nd dose Date of 3rd dose
<p>6. Laboratory Checkup (Attached document is required)</p>	<p>Complete blood count, Urinalysis, FBS, Chol, TG, Creatinine, AST, ALT, AP</p>
<p>7. Chest X-ray (Attached document, not the film, is required)</p>	<ul style="list-style-type: none"> • • If others, please describe • Dated on
<p>8. Health Assessment Certificate (Attached document is required)</p>	<ul style="list-style-type: none"> • • If others, please describe • Dated on

REMARK:

No resident/ fellow will be able to proceed with orientation until this form is completed within the last 6 months before training