Immune Assessment Form

Only to be completed for Non-Employees who wish to serve for one month or less.

Weill Cornell Medicine requires that all Non-Employees show proof of immunity for **Measles, Mumps, Rubella, and Varicella** in the form of assays of anti-viral antibodies or immunization records. **History of having any of these diseases in the past is not sufficient proof of full immunity**. In addition, a **PPD or IGRA / Quantiferon** blood test is required within 60 days of the start date. **Immunity to Hepatitis B is strongly recommended where patients are present and there is risk of blood and body fluid exposure.** Completion of a Hepatitis B series AND post immunization titer. If titer is negative, need to check a hepatitis B surface antigen. If no antigen detected, repeat of booster doses of vaccine per standard schedule can be offered.

This form must be filled out by the applicant's primary care provider. Any attachments cannot be used as a substitution for filling out this form. If any part of the form is incomplete or pending, the applicant will not be allowed to start regardless of the start date.

Regarding the COVID-19 vaccine, are you fully vaccinated (2 doses of Pfizer/Moderna or 1 dose J&J Janssen vaccine)? □ **YES** □ **NO** □ **N/A (minors 17 and younger)**

COVID-19 vaccine is required unless you have a documented medical contraindication to the vaccine. Please have your healthcare provider fill out your COVID-19 vaccine information in Part 2. (Note: If you received the Johnson & Johnson vaccine you must have one dose documented, whereas for Moderna & Pfizer, two doses must be documented.):

a. If you have a documented medical contraindication to the vaccine, please check off the box below:
□ I agree to adhere to standard precautions, when applicable: personal protective equipment, respiratory hygiene/cough etiquette and safe infection practices.

Name (Last, First, Middle Initial)	**Date of Birth**

Measles Mumps Rubella Vaccine (MMR) (1st Vaccine after 1st birthday) **OR**	Measles/Rubeola Antibody Mumps Antibody Rubella Antibody
Measles Date: ___/___/___ Mumps Date: ___/___/___ (*Not mandatory, but strongly encouraged*) Rubella Date: ___/___/___	Result: □ Positive □ Negative Result: □ Positive □ Negative Result: □ Positive □ Negative
Varicella Vaccination (2 Vaccines) **OR**	Varicella Titer
Date 1: ___/___/___ Date 2: ___/___/___	Date: ___/___/___ Result: □ Positive □ Negative

Tdap within the past 10 years**.** *(Not mandatory, but strongly encouraged)*
Tdap Date: ___/___/___

Tuberculosis Screening
May provide either IGRA testing results OR 2 Mantoux TB skin tests

IGRA or Quantiferon blood test (within 60 days of scheduled visit start date)
Date: ___/___/___ Result: □ Positive □ Negative

OR

2 Mantoux TB Skin Tests (PPD)
(The 1st test within prior 12 months and the 2nd test within 60 days prior to the scheduled visit start date) OR present physician documentation of completed latent Tb treatment.

PPD #1 (within prior 12 months of scheduled visit start date)	**PPD #2** (within 60 days scheduled visit start date)
Plant Date: ___/___/___ Read Date (48-72 hours after plant): ___/___/___ Result: _____ mm (must be documented as a numerical value)	Plant Date: ___/___/___ Read Date (48-72 hours after plant): ___/___/___ Result: _____ mm (must be documented as a numerical value)

If positive, chest x-ray date (must be done after positive test and within prior 12 months** of scheduled visit start date)*

Date:___/___/___

*Results:*_____

Hepatitis B & C

□ Have accepted and completed the series of ***Hepatitis B*** vaccinations.

□ Declined ***Hepatitis B*** vaccination and signed the OSHA declination form.
https://www.osha.gov/SLTC/etools/hospital/hazards/bbp/declination.html

Hepatitis B Antibody **Date: ___/___/___** Result: □ Positive □ Negative (If neg., then HBsAg needs to be performed)	**Hepatitis B Antigen (within 6 months of scheduled visit start date)** Date: ___/___/___ Result: □ Positive □ Negative (Perform only if HBsAb is negative)	**Hepatitis C Antibody (within 6 months of scheduled visit start date)** Date: ___/___/___ Result: □ Positive □ Negative

Hepatitis B Vaccination dates:

#1 _____, _____, _____ **#2 _____, _____, _____** **#3 _____, _____, _____**

Flu vaccine name _____ and date: ___/___/___ Flu vaccine (if applicable) during influenza season (TBD by NYS DOH). Dated immunization record must be provided and include the formulation, dose and administration as given by health care provider/pharmacist.

□ Check this box on the left if you have a documented medical contraindication to the vaccine or are exempt for religious reasons.

COVID-19 vaccine date:

COVID-19 vaccine name: _____; dose #1 date: ___/___/___; Lot# _____

COVID-19 vaccine name: _____; dose #2 date: ___/___/___; Lot# _____

Optional Booster COVID-19 vaccine name: _____; Date: ____/___/___; Lot# _____

Dated immunization card must be provided and include health care provider/pharmacist information and specific vaccine name. COVID-19 vaccine is required, unless you have a documented medical contraindication to the vaccine. If you received the Johnson & Johnson vaccine, you must have one dose documented, whereas for Moderna & Pfizer, two doses must be documented.

EXAMINING HEALTH PROFESSIONAL'S STATEMENT

I have determined that the above named is free from any communicable disease which is of potential risk to patients, employees or students or which might interfere with the performance of applicant duties.

Name (Please Print)	Occupation	State License No.
Address		Telephone Number
Signature		Date