Proof of Immunization for Clinical Placements at UFV

This form must be fully completed, legible, signed and stamped by a qualified physician with the official clinic/ laboratory stamp. Please enclose a copy of your vaccinations record.

Patient's Name (nombre paciente):

DOB (fecha de nacimiento):

Doctor (nº colegiado):

I, certify that (certifico que) _____has received the below immunizations on the dates listed below (ha recibido la inmunización descrita abajo) and is physically and mentally fit to carry out clinical duties:

MMR (Vacuna Triple Vírica): _____ _____
First dose (1ºdosis) **Second dose (2ºdosis)**

Varicella (Varicela): _____ **or** _____
Vaccine **Varicella Titer (anticuerpos varicela)**

Screening for Tuberculosis: _____ **or** _____
Mautous test (PPD) **(Mantoux)** **(radiografía de tórax) Chest Xray.**

Hepatitis B
Vaccinations:
Date of 1. vaccination:
Date of 2. vaccination:
Date of 3. vaccination
Date of booster:
Date and result of **Hepatitis B surface** antibody blood test (Anti HBs AK):
Date and result of **Hepatitis B core** antibody blood test (Anti HBc AK):

Hepatitis C
Date and result of **Hepatitis C antibody** blood test, taken within the **last three months**:

_____ _____
Doctor's Name (Nombre del médico) **Signature (Firma)**

_____ _____
Date signed (fecha de firma) **Official Stamp (Sello oficial)**