Stabsstelle Klinikentwicklung
Arbeitsmedizin Med Campus
Krankenhausstraße 9, 4021 Linz
Telefon: 05 7680 83 22021
E-Mail:arbeitsmedizin.mc@kepleruniklinikum.at

Kepler Universitäts Klinikum

Immunization for Health Care Workers

at the Kepler Universitätsklinikum

☐ Med Campus II., Krankenhausstraße 7a, 4020 Linz
☐ Med Campus III., Krankenhausstraße 9, 4021 Linz
☐ Med Campus IV., Krankenhausstraße 26-30, 4020 Linz

We ask you to complete this questionnaire as soon as possible and send it to **Arbeitsmedizin** with a **copy of your vaccination record or digital certificates.**

name:	**social security number (SSN) / date of birth**
	planned activity:
adress:	**department:**
	course / vintage:
mobile phone:	**training site:**
private email:	Date from: Date to:

Mandatory vaccinations	**date of immunization**	**vaccination recommended**
Measles – Mumps - Rubella (two dose vaccine required)	1. Immunization 2. Immunization	Yes ☐ No ☐
No two dose vaccination, serological testing is required	Immunity to Measles: Immunity to Mumps: Immunity to Rubella:	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Varicella	History of disease - Date: Immunity to varicella:	Yes ☐ No ☐
No history of disease, serological testing neg	1. Immunization varicella 2. Immunization varicella	Yes ☐ No ☐

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Hepatitis B (at least 3 dose vaccination) Name of vaccine:	1. Immunization 2. Immunization 3. Immunization Booster Injection: Serological testing:	Yes ☐ No ☐ Next due vaccination:

Recommended vaccinations	**Last date of immunization**	**vaccination recommended**
Hepatitis A (for High-risk group kitchen mandatory) At least vaccinated once Name of vaccine:	1. Immunization 2. Immunization	Yes ☐ No ☐
Pertussis		Yes ☐ No ☐
Poliomyelitis		Yes ☐ No ☐
Diphterie		Yes ☐ No ☐
Tetanus		Yes ☐ No ☐

Medical confirmation:

I hereby confirm sufficient immunity against

☐ **Measles/Mumps/Rubella** ☐ **Varicella and**

☐ **Hepatitis B**

I hereby confirm the accuracy of the information on the vaccination records from:

Name: ……, SSN and Date of Birth.: ……

Date: …… Signature and stamp of the physician: ……