Arbeitsmedizin Neuromed Campus
Wagner-Jauregg-Weg 15, 4020 Linz
Telefon: 05 7680/87-22021
Fax: 05 7680/87-42021
E-mail: Arbeitsmedizin.NMC@kepleruniklinikum.at

Kepler Universitäts Klinikum

Proof of Immunization for Health Care Workers

at the Kepler Universitätsklinikum

Please send the completed and signed form **no later than 8 weeks** before the start of your internship to ARBEITSMEDIZIN at the Kepler Universitätsklinikum.

Please fill in mandatory:

Surname: **First name:** **Address:**	***Please mark as appropriate:*** ☐ compulsory internship ☐ holiday work ☐ voluntary placement ☐ clerkship ☐ leasing force ☐ student ☐ hospitable doctor ☐Other: _____	
Social security number/Date of birth:	**Start date:**	**End date:**
Mobile phone number: **E-mail:**	**Planned activity:** **Department:**	
Home university:	**Contact person/internship carer an the Kepler Universitätsklinikum:**	

Mandatory vaccinations	**Date of immunization**	**Vaccination recommended**
Measles – Mumps – Rubella (two dose vaccine required)	1. Immunization 2. Immunization	Yes ☐ No ☐
If you don't have a 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 ☐
If there is no history of disease or if the serological testing is negative	1. Immunization varicella 2. Immunization varicella	Yes ☐ No ☐

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

Recommended vaccinations	**Last date of immunization**	**Vaccination recommended**
Pertussis		Yes ☐ No ☐
Poliomyelitis		Yes ☐ No ☐
Diphterie		Yes ☐ No ☐
Tetanus		Yes ☐ No ☐
Hepatitis A Name of vaccine:	1. Immunization 2. Immunization	Yes ☐ No ☐

Physician‘s confirmation:

I hereby confirm sufficient immunity against

☐ **Measles/Mumps/Rubella**,

☐ **Varicella** and

☐ **Hepatitis B**.

I hereby confirm the accuracy of the information on the voluntary vaccination records.

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