

Immunization Form Instructions:

All visiting medical students must submit a completed (AAMC) Association of American Medical Colleges Immunization Form that has been typewritten and signed by their healthcare provider.

- All 4 pages of the AAMC Immunization Form must be completed and include supporting health vaccination, Hepatitis B Surface Antibody lab titer report and test result documentation.
- The latest Td/Tdap vaccine must be less than 10 years old at start of clerkship.
- TB Test result and Influenza vaccine results should be up-to date in accordance with our health facility policy for health clearance approval:
 - **Domestic Students** – Influenza vaccine completed annually during each flu season. TB Test result cannot be older than 12 months prior to clerkship start date.
 - **Global Partner (International) Students Only** – Influenza vaccine completed annually during each flu season and a TB QuantiFERON Gold Blood Test completed only in the United States within the past 6 months prior to clerkship start. *If accepted for clerkship, international students can schedule appointment to receive TB testing and other vaccinations needed at Northwestern Student Health.*
- No other immunization form may be substituted.
- All health documents must be transcribed in ENGLISH.

Where to Submit Form:

- *Domestic Students* – submit via VSAS portal
- *International Students* – submit via email to Visting Student Clerkship Coordinator

****Failure to follow all instructions will result in an incomplete application.****

AAMC Standardized Immunization Form

Last Name:		First Name:		Middle Initial:	
DOB:		Street Address:			
Medical School:		City:			
Cell Phone:		State:			
Primary Email:		ZIP Code:			
Student ID:					

MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.					Copy Attached
Option 1	Vaccine	Date			
MMR -2 doses of MMR vaccine	MMR Dose #1				<input type="checkbox"/>
	MMR Dose #2				
Option 2	Vaccine or Test	Date			
Measles -2 doses of vaccine or positive serology	Measles Vaccine Dose #1		Serology Results Qualitative Titer Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/>
	Measles Vaccine Dose #2				
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml		
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1		Serology Results Qualitative Titer Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/>
	Mumps Vaccine Dose #2				
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml		
Rubella -1 dose of vaccine or positive serology			Serology Results Qualitative Titer Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/>
	Rubella Vaccine				
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml		
Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide dates of last Td and Tdap					
	Tdap Vaccine (Adacel, Boostrix, etc)				<input type="checkbox"/>
	Td Vaccine (if more than 10 years since last Tdap)				
Varicella (Chicken Pox) - 2 doses of vaccine or positive serology					
	Varicella Vaccine #1		Serology Results Qualitative Titer Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/>
	Varicella Vaccine #2				
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml		
Influenza Vaccine - 1 dose annually each fall					
Date of last dose		Date			<input type="checkbox"/>
	Flu Vaccine				

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Hepatitis B Vaccination - 3 doses of Engerix-B, Recombivax or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥ 10 mIU/mL is positive for immunity. If the test result is negative, repeat another Hepatitis B vaccine series followed by a repeat test titer. If the Hepatitis B Surface Antibody test is negative after the repeat vaccine series, a "non-responder" status is assigned. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information.				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Engerix-B, Recombivax, Twinrix) 2-dose vaccines (Heplisav-B)	3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Repeat Hepatitis B Series <u>Only If no response to primary series</u> Heplisav-B only requires two doses of vaccine followed by antibody testing		3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.			<input type="checkbox"/>
Additional Documentation				
<u>Some institutions</u> may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience you may also be required to provide proof of vaccines such as yellow fever or typhoid.				
Vaccination, Test or Examination	Date	Result or Interpretation		
Physical Exam (if required)			<input type="checkbox"/>	

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TUBERCULOSIS (TB) SCREENING – All U.S. healthcare personnel are screened pre-placement for TB. Results of the last (2) TB Skin Tests (TSTs) or (1) IGRA blood test are required **regardless** of prior BCG status. The 2-step TST protocol must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. The second TST must be placed at least 1 week after the first TST read date. If you have a history of a positive TST (PPD) ≥ 10 mm or a positive IGRA blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.

Skin test or IGRA results should not expire during proposed elective rotation dates
or
must be updated with the receiving institution prior to rotation.

Tuberculosis Screening History

Please complete only one TB section based on your history	Section A		Date Placed	Date Read	Result	Interpretation
	History of Negative TB Skin Test or Blood Test <small>T-spots or QuantiFERON TB Gold blood tests for tuberculosis</small> <small>Use additional rows as needed</small>	TST #1			_____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
		TST #2			_____ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
			Date	Result		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
	Section B		Date Placed	Date Read	Result	
	History of Positive Skin Test or Positive Blood Test	Positive TST			_____ mm	
				Date	Result	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
		Chest X-ray*		*Provide documentation or result		
		Treated for latent TB infection (LTBI)?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Date of Last Annual TB Symptom Questionnaire				



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Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

Healthcare Professional Signature:		Date:
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone: () - Ext:		
Fax: () -		
Email Contact:		

*Sources:

1. Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45
3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19
4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31
5. Sosa LE, Nijie GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w