

# Contracted Health Care Worker Examination and Immunization Verification Form

Infectious Disease	Dates (DD-MM-YYYY)	Proof of Immunity
Varicella (chickenpox)*	1. <input type="text"/> - <input type="text"/> - <input type="text"/> 2. <input type="text"/> - <input type="text"/> - <input type="text"/>	Physician documented varicella (attach) OR Positive IgG titer: <input type="text"/> - <input type="text"/> - <input type="text"/> (titer date)
Measles*	1. <input type="text"/> - <input type="text"/> - <input type="text"/> 2. <input type="text"/> - <input type="text"/> - <input type="text"/>	Positive IgG titer date <input type="text"/> - <input type="text"/> - <input type="text"/>
Mumps*	1. <input type="text"/> - <input type="text"/> - <input type="text"/> 2. <input type="text"/> - <input type="text"/> - <input type="text"/>	Positive IgG titer date <input type="text"/> - <input type="text"/> - <input type="text"/>
Rubella*	1. <input type="text"/> - <input type="text"/> - <input type="text"/> 2. <input type="text"/> - <input type="text"/> - <input type="text"/>	Positive IgG titer date <input type="text"/> - <input type="text"/> - <input type="text"/>
Tetanus (T, Td, Tdap)*	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Diphtheria (Td, Tdap)*	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Pertussis (Tdap)*	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Influenza (seasonal) (all HCWs)	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Tuberculosis (all HCWs with negative history of TB or exposure)	1. <input type="text"/> - <input type="text"/> - <input type="text"/> 2. <input type="text"/> - <input type="text"/> - <input type="text"/> } 2-52 weeks apart Result (circle one): Negative Positive	Blood assay for <i>M. tuberculosis</i> date <input type="text"/> - <input type="text"/> - <input type="text"/> Result (circle one): Negative Positive
Tuberculosis (all HCWs with positive history of TB or exposure)	Latent TB infection prophylaxis? Year <input type="text"/> started or complete (circle one)	CXR date <input type="text"/> - <input type="text"/> - <input type="text"/> Result (circle one): Negative Positive
Hepatitis B (only applies to HCWs with potential occupational exposure to bloodborne pathogens)	1. <input type="text"/> - <input type="text"/> - <input type="text"/> 2. <input type="text"/> - <input type="text"/> - <input type="text"/> 3. <input type="text"/> - <input type="text"/> - <input type="text"/> If necessary (i.e., if first titer negative): 4. <input type="text"/> - <input type="text"/> - <input type="text"/> 5. <input type="text"/> - <input type="text"/> - <input type="text"/> 6. <input type="text"/> - <input type="text"/> - <input type="text"/>	IgG (HBsAb) titer date <input type="text"/> - <input type="text"/> - <input type="text"/> Result (circle one): Negative Positive IgG (HBsAb) second titer date <input type="text"/> - <input type="text"/> - <input type="text"/> Result (circle one): Negative Positive Counseling provided date (if repeat titer negative) <input type="text"/> - <input type="text"/> - <input type="text"/>
Other (identify)	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Latex sensitivity screening	<input type="text"/> - <input type="text"/> - <input type="text"/>	History IS / IS NOT (circle one) consistent with latex sensitivity

\* Applies only to HCWs with direct patient contact.

I certify that \_\_\_\_\_ was examined on -- and WAS / WAS NOT found to  
*name of health care worker* *mm* *dd* *yyyy* *circle one*  
 be in good health, meeting the immunization and screening required above, and free of any medical condition or infectious disease that may prevent his/her ability to perform services as a Health Care Worker.

Provider's Signature: \_\_\_\_\_ Provider's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

### This section for Navy use only

Completed form and accompanying documentation reviewed and found complete.

Reviewer's signature \_\_\_\_\_ Name (print) \_\_\_\_\_ Date \_\_\_\_\_  
 NAVMED 6260/91 (08/2017)