Working Well Clinic
Doctor's Office Building
720 Harrison Avenue
Boston, MA 02118-2393
Phone 617-638-8400
Fax 617-638-8406
workingwellclinic@BMC.org

____
Last Name, First Name, M.I.

______________________ ______________________
Date of Birth (MM/DD/YYYY) **Department**

______________________ ______________________
Social Security# **Projected Start Date**

____
Email address

☐ **I was a BU student** ☐ **I was a BMC resident / fellow**

BOSTON MEDICAL CENTER RESIDENT & FELLOW IMMUNIZATION FORM

Completed record of immunizations and screening procedures must be up to date and sent to the Working Well Clinic for clearance to start your training program. If vaccinations are in process, provisional clearance will be granted. *Self-attestation is not accepted*. School, employment, primary care provider, travel, or military immunization records; original lab or chest x-ray results can be submitted in lieu of this form.

Immunization	**Vaccine Date** or	**Date of titer demonstrating immunity**
MMR no. 1	____ / ____ / ____	
MMR no. 2	____ / ____ / ____	
or		
Measles 1 (if no MMR)	____ / ____ / ____ or	____ / ____ / ____
Measles 2 (if no MMR)	____ / ____ / ____	
Mumps 1 (if no MMR)	____ / ____ / ____ or	____ / ____ / ____
Mumps 2 (if no MMR)	____ / ____ / ____	
Rubella (if no MMR)	____ / ____ / ____	
Rubella (if no MMR)	____ / ____ / ____ or	____ / ____ / ____
Tetanus, Diphtheria, Pertussis (Tdap)	____ / ____ / ____	
For Hepatitis B, dates of vaccinations with titer is preferred BUT a titer alone is acceptable		
Hepatitis B no. 1	_____/____/____	
Hepatitis B no. 2	____ / ____ / ____	
Hepatitis B no. 3	____ / ____ / ____	HBsAB ___/___/___
Hepatitis B #4, #5, #6 (only if applicable)	____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____	
Varicella 1	____ / ____ / ____ or	____ / ____ / ____
Varicella 2	____ / ____ / ____	
Varicella (Chicken Pox)	Date of provider verified disease ____ / ____ / ____	
Two Negative Tuberculin Skin Test (TST)	(If TST+, complete TST+ Form instead)	
Most recent TST (must be within 3 months of start; result of other tests, such as IGRA not accepted.)	Second most recent TST (must be within 12 months of most recent TST)	
Plant Date ____ / ____ / ____ **Read Date** ____ / ____ / ____ ______mm	**Plant Date** ____ / ____ / ____ **Read Date** ____ / ____ / ____ ______mm	

______________________________________ MD/NP/PA ______________________ ________________
Print Name; Signature State, License Number Date

OEM Review: MD/NP/PA/RN Signature____ Date________________
☐ Clearance Granted ☐ Provisional Clearance Until: ___/___/___☐ Other action: ____

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Positive Tuberculosis Skin Test Documentation

This form is to be completed by your treating provider. School, employment, primary care provider, TB clinic, travel, or military immunization records; original lab or chest x-ray results can be submitted in lieu of this form. *Self-attestation is not acceptable.*
Information must be sent to the Working Well Clinic

Positive Tuberculin Skin Test (TST) Documentation

Date planted: ____ / ____ / ____ Date Read: ____ / ____ / ____ Results in ___________mm

If negative, and no documentation of + TST, please submit the results of 2 TB skin tests as noted on the immunization page.

Chest x-ray result (done after + TST)

Date: ____ / ____ / ____ ☐ Normal ☐ Abnormal:______________________________________
(Describe)

Clinical Evaluation Date: ___ / ____ / ____

☐ No symptoms (no fever, night sweats, unexplained weight loss, unexplained fatigue, persistent cough, coughing up blood)

☐ Abnormal:____
(Describe)

Treatment:

☐ Medication counseling completed – discussed pros/cons, options/recommendations: Date_________________

☐ Has documented treatment history: Date________________ Treatment completed: ☐ Yes ☐ No

Clinician Signature:

____ MD/NP/PA __________________________ _________________
Print Name; Signature State, License Number Date

OEM Review: MD/NP/PA/RN Signature____ Date________________

☐ Clearance Granted ☐ Provisional Clearance Until: ___/___/___☐ Other action: ____

Form Version 3/1/15 G: OEM forms/Preplacement/Immunization & Screening letters