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

BOSTON MEDICAL CENTER 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. *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	____ / ____ / ____	Measles___/___/___ Mumps___/___/___ Rubella___/___/___
MMR no. 2	____ / ____ / ____	
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	____ / ____ / ____	
Flu shot	____/_____/_____	
Two Negative TB skin tests (TST) OR IGRA (T-Spot or Q-Gold blood test)	(If TST+ or IGRA +, complete TST+/IGRA+ Form instead)	
Most recent TST (must be within 3 months of start)	Plant Date ____ / ____ / ____ Read Date ____ / ____ / ____ Induration: _____mm	
Second most recent TST (must be within 12 months of start date)	Plant Date ____ / ____ / ____ Read Date ____ / ____ / ____ Induration: _____mm	
IGRA test (must be within 6 months of start date)	Circle one: T-SPOT Q-Gold	___/___/___

_____ MD/NP/PA _____ _____
Provider Name & Signature State, License Number Date